East Lancashire Hospitals
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

East Lancashire Hospitals NHS Trust

TRUST BOARD MEETING (OPEN SESSION)

11 SEPTEMBER 2019, 13.00

SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

v = verbal
p = presentation
d = document
✓ = document attached

OPENING MATTERS				
TB/2019/107	**Chairman's Welcome**	Chairman	v	
TB/2019/108	**Open Forum** To consider questions from the public	Chairman	v	
TB/2019/109	**Apologies** To note apologies.	Chairman	v	
TB/2019/110	**Declaration of Interest** To note the directors register of interests and note any new declarations from Directors.	Chairman	d	
TB/2019/111	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 10 July 2019.	Chairman	d✓	Approval
TB/2019/112	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2019/113	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2019/114	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2019/115	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive and Acting Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2019/116	**Patient Story** To receive and consider the learning from a patient story.	Executive Director of Nursing	p	Information/ Assurance
TB/2019/117	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Acting Executive Medical Director	d✓	Assurance/ Approval
TB/2019/118	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Acting Executive Medical Director	d✓	Assurance/ Approval

TB/2019/119	**Serious Incidents Requiring Investigation Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Acting Executive Medical Director	d✓	Information/ Assurance
ACCOUNTABILITY AND PERFORMANCE				
TB/2019/120	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed, with items being raised by exception: • Introduction (Acting Chief Executive) • Safe (Acting Executive Medical Director and Executive Director of Nursing) • Caring (Executive Director of Nursing) • Effective (Acting Executive Medical Director) • Responsive (Director of Operations) • Well-Led (Executive Director of HR and OD and Executive Director of Finance)	Executive Directors	d✓	Information/ Assurance
TB/2019/121	**Doctors Appraisal and Revalidation Annual Report**	Acting Executive Medical Director	d✓	Information/ Assurance
TB/2019/122	**Emergency Preparedness and Resilience Report (summary)**	Executive Director of Service Development	v	Information/ Assurance
STRATEGY				
TB/2019/123	**Integration and Intermediate Care (Pennine Lancashire Update)**	Acting Chief Executive	p	Information/ Assurance
GOVERNANCE				
TB/2019/124	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties	Committee Chair	d✓	Information/ Assurance
TB/2019/125	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance/ Approval
TB/2019/126	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties.	Committee Chair	d✓	Information/ Assurance/ Approval
TB/2019/127	**Trust Charitable Funds Committee Update Report** To note the matters considered by the Committee in	Committee Chair	d✓	Information/ Assurance/ Approval

	discharging its duties.			
TB/2019/128	**Remuneration Committee Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
TB/2019/129	**Trust Board Part Two Information Report** To note the matters considered by the Committee in discharging its duties	Chairman	d✓	Information
FOR INFORMATION				
TB/2019/130	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2019/131	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2019/132	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Is the Board shaping a healthy culture for the Board and the organisation and holding to account? • Are the Trust's strategies informed by the soft intelligence from local people's needs, trends and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation? • Does the Board take into account the collaboration agenda when setting its strategy? • To what extent have we made collaboration and system working part of our business as usual?	Chairman	v	
TB/2019/133	**Date and Time of Next Meeting** Wednesday 13 November 2019, 1.00pm, Seminar Room 6, Learning Centre, Royal Blackburn Teaching Hospital.	Chairman	v	

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 111

11 September 2019

Purpose Action

Title	Minutes of the Previous Meeting
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The minutes of the previous Trust Board meeting held on 10 July 2019 are presented for approval or amendment as appropriate.

Report linkages

Related strategic aim and corporate objective	As detailed in these minutes
Related to key risks identified on assurance framework	As detailed in these minutes

Impact

Legal	Yes	Financial	No
Maintenance of accurate corporate records			
Equality	No	Confidentiality	No

Previously considered by: NA

(111) Minutes of the Previous Meeting

EAST LANCASHIRE HOSPITALS NHS TRUST
TRUST BOARD MEETING, 1.00PM, 10 JULY 2019
MINUTES

PRESENT

Professor E Fairhurst	Chairman	Chairman
Mr K McGee	Chief Executive/Accountable Officer	
Dr D Riley	Acting Chief Executive	
Mr S Barnes	Non-Executive Director	
Mr H Catherall	Associate Non-Executive Director	Non-voting
Mr M Hodgson	Executive Director of Service Development	Non-voting
Mrs C Hughes	Executive Director of Communications and Engagement	Non-voting
Miss N Malik	Non-Executive Director	
Mr K Moynes	Director of HR and OD	Non-voting
Mrs F Patel	Associate Non-Executive Director	
Mrs C Pearson	Executive Director of Nursing	
Mr R Smyth	Non-Executive Director	
Professor M Thomas	Associate Non-Executive Director	Non-voting
Mr M Wedgeworth	Associate Non-Executive Director	Non-voting
Mr D Wharfe	Non-Executive Director	
Mr J Wood	Executive Director of Finance	

IN ATTENDANCE

Mrs M Almond	Senior Patient Experience Facilitator	For Item TB/2019/089
Mrs A Bosnjak-Szekeres	Associate Director of Corporate Governance/ Company Secretary	
Mrs J Butcher	Freedom to Speak Up Guardian	For Item TB/2019/094
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs EL Cooke	Senior Communications Manager	Observer
Mrs J Gaskill	End of Life Facilitator	For Item TB/2019/089
Mrs S Gilligan	Director of Operations	
Miss J Iddon	Associate Medical Director, Governance	On behalf of Dr I Stanley
Miss K Ingham	Corporate Governance Manager/Assistant Company Secretary	Minutes

Mrs C Langton	Lead Nurse Specialist Palliative Care	For Item TB/2019/089
Mrs U Krishnamoorthy	Clinical Director, Medical Director's Office	Observer
Mrs A O'Neil	Matron, Older People Rapid Assessment Unit	For Item TB/2019/089
Mr D Parkinson	Site Security Lead	Observer
Mrs K Quinn	Operational Director of HR and OD	
Mr B Todd	Member of the Public	Observer
Mrs S Ridehalgh	Patient Experience Facilitator	For Item TB/2019/089
Mrs A Turner	Directorate Lead for Allied Health Professionals	Observer

APOLOGIES

Dr I Stanley	Acting Executive Medical Director

TB/2019/080 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed the Directors and members of the public to the meeting, particularly Mr Catherall and Miss Iddon and Mrs Gilligan.

TB/2019/081 OPEN FORUM

Mr Todd stated that he had recently received a number of appointments for the eye clinic at Burnley General Teaching Hospital, some of which he had needed to reschedule due to their timings in the day. He asked the Trust to consider the timing of appointments when they were being set for patients, as it would be very difficult, if at all possible, for patients that rely on public transport to return to the western side of the area after 6.00pm. Dr Riley offered to liaise with Mr Todd outside the meeting to rectify this matter.

RESOLVED: Dr Riley will liaise with Mr Todd regarding the above matter.

TB/2019/082 APOLOGIES

Apologies were received as recorded above.

TB/2019/083 DECLARATIONS OF INTEREST REPORT

Directors received the report for information. Directors noted that there were three additions to be made to the register, they were noted to be:

a) Mr McGee's joint appointment as Chief Executive of the Trust and Blackpool Teaching Hospitals NHS Foundation Trust.

b) Mr Moynes's joint appointment as Executive Director of HR and OD at east

Lancashire Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust.

c) A declaration in relation to the agreement for Mrs Hughes to provide strategic communications and engagement advice to the Board at Lancashire Care NHS Foundation Trust.

RESOLVED: **Directors noted the position of the Directors' Register of Interests and the updates that were required.**

TB/2019/084 MINUTES OF THE PREVIOUS MEETING

Directors having had the opportunity to review the minutes of the previous meeting approved them as a true and accurate record, pending the inclusion of Mrs Quinn as being in attendance and Mr Hodgson having given his apologies.

RESOLVED: **The minutes of the meeting held on 8 May 2019 were approved as a true and accurate record pending the aforementioned corrections.**

TB/2019/085 MATTERS ARISING

There were no matters arising from the minutes of the previous meeting.

TB/2019/086 ACTION MATRIX

All items on the action matrix were reported as complete or were to be presented as agenda items at this meeting or subsequent meetings. The following updates were provided:

TB/2019/061: Action Matrix - Mrs Hughes reported that a programme of work had been developed and included the introduction of guest bloggers in the Chief Executive's weekly blog, listening events, patient safety walkrounds and divisional tea parties.

TB/2019/068: Integrated Performance Report – Mrs Quinn confirmed that the temporary staffing issues discussed at the previous meeting continued. She went on to report that the Trust had recently had the results of an internal audit report from Mersey Internal Audit Agency (MIAA), the Trust's internal auditors, relating to medical staffing processes which had been given a rating of 'Substantial Assurance'.

TB/2019/073: Quality Committee Update Report – Mrs Pearson reported that the funding for the supernumerary Co-ordinator in the Family Care Division had been approved and the Division were in the process of recruiting to the post.

RESOLVED: **The position of the action matrix was noted.**

TB/2019/087 CHAIRMAN'S REPORT

Professor Fairhurst reported that, since the last meeting, she had been a panel member for a Price Waterhouse Cooper programme for Non-Executive Directors on the topic of 'What Makes a Good Non-Executive Director'.

Directors noted that Professor Fairhurst was continuing her role regarding the wider governance of NHS Trusts and were informed of her recent participation on the panels for the recruitment in several North West Trusts.

RESOLVED: Directors received and noted the update provided.

TB/2019/088 CHIEF EXECUTIVE'S REPORT

Mr McGee confirmed that he would present sections one and two of the report, whilst Dr Riley would present the remainder of the report. He confirmed that Ms Pritchard had been appointed as the Chief Operating Officer for NHS Improvement/England. This was viewed a good appointment across the sector, as she has an excellent understanding of operational pressures across the NHS.

Mr McGee went on to report that the Lancashire and South Cumbria Integrated Care System (ICS) partners were working together to increase collaboration. In relation to the Integrated Care Partnership (ICP) across the Pennine Lancashire areas, Mr McGee reported that solid governance foundations were being developed which enable Commissioners and providers of services to work together to ensure that the population of the area receive the best health and social care possible.

Dr Riley highlighted the section of the Chief Executive's report that detailed the documents and contracts that the Trust Seal had been used on since the last meeting. He went on to request approval from the Board for the re-awarding for the third time of Silver Ward Status to the Breast and Gynaecology Ward at Burnley General Teaching Hospital. The Board approved the award and congratulated the ward for maintaining their high standards.

Dr Riley confirmed that the Mayor of Burnley has chosen the Trust's Charity, ELHT&Me as her charity of choice for 2019 and pledged to raise £25,000 for the charity. In addition, the NHS Big Walk that was held on 23 June raised in excess of £10,000 for the charity.

Dr Tim Clarke, Consultant Anaesthetist was presented with the Anaesthesia Clinical Services Accreditation by the Royal College of Anaesthetists. Four of the Trust's Emergency Department nursing staff are now accredited bereavement co-ordinators.

Miss Malik welcomed the good news within the report and suggested that the Trust develop a virtual trophy cabinet to show to the wider population the good work that the Trust is doing.

RESOLVED: **Directors received the report and noted its content.**

The Board approved the re-award of silver ward status to the Breast and Gynaecology ward at Burnley General Teaching Hospital.

The Trust will develop a virtual trophy cabinet to show to the wider population the good work that the Trust is doing.

TB/2019/089 PATIENT STORY

The patient story was from the perspective of the wife of a patient who had been treated by the Trust during his illness and particularly in his last few weeks of life. In addition, the story touched on a range of other service, including social care, primary care and the voluntary sector.

The patient worked at St Christopher's School in Accrington as a woodwork technician where he retired aged 51. Whilst at home he did a great deal in the home and garden. He also continued to work with wood, making furniture in his workshop at home.

His wife started to notice his declining health in 2013. At first, she thought it was his eyesight, but as time went on things got worse and he began to forget things and eventually was unable to put his clothing on correctly. She took him to see their GP who referred him to the Burnley Memory Clinic. When he attended the clinic the staff carried out some tests and he was diagnosed with short term memory loss.

A few months later he went back to see his doctor and he was diagnosed with Alzheimer's disease. The GP confirmed that a formal letter of diagnosis would follow from the hospital, but the letter was not received. The patient's wife stated that she could not be sure whether it really had never arrived or whether her husband had unintentionally thrown it away.

In 2017 the family GP suggested that the patient's wife had a break from her caring duties and it was arranged that the patient would be looked after in a specialised residential facility whilst she was away. However two days before she was due to fly, the home called to inform her that they were unable to manage him and she would have to find an alternative placement for her husband. After calls to Social Services, a suitable alternative placement was found. The home was registered for people with Alzheimer's and he was moved there. Following a poor experience at the second home, his wife set about trying to find another suitable residential home for him. Due to his declining health the GP had confirmed that he was not fit to live at home without help. A few days later he was taken to the Emergency Department at Royal Blackburn Teaching Hospital following a fall. He was seen by a doctor

from the Medicine for Older People (MfOP) directorate. The doctor explained that he had suffered an overdose of medication. They then contacted Social Services, the Safeguarding Team and the CQC to report the incident.

Whilst in hospital, the patient was on Ward C1 where he was diagnosed with Sepsis. When stabilised, he was moved to ward C3 for almost a week prior to discharge to a suitable residential home in Clayton. Whilst there, he was able to get the help he needed to start walking, eating, and he put on weight, but as his mobility improved he needed to find an alternative residential setting. Following an unsuccessful placement, he was referred to the Rapid Intervention and Treatment Team (RITT) to find an alternative residential home.

The patient's wife had no complaints about the hospital in terms of the treatment he received and commented that the Sisters on Wards C1 and C3 were always welcoming and nice and she felt at home there. At the point of discharge, the patient's wife asked whether it would be possible for her husband to be discharged home with a suitable package of care, which was agreed and implemented. He managed to remain in his home with support for a further 12 months when he contracted an infection which was treated with antibiotics. Three months later he was admitted to ward D3 and after a quick discharge and readmission it became clear that he would not make a recovery. Following discussions with healthcare professionals, it was agreed that the patient would need to be brought back into hospital for care, where he died a week later.

The patient's wife reiterated that she had no complaints about the Trust or the treatment he husband had received.

However, she had felt that there was too much paperwork involved in the immediate aftermath of his death. She had asked for a particular item of clothing to be returned to her after he died, but it was not possible. In addition she commented that on the morning of the day that her husband died, she had received a call from one of the nurses on the ward informing her that her husband's breathing had changed. At the time she thought that the call was merely an update on his condition, but later found out that this was an indicator of his imminent decline and as a result had not been able to be with him when he died.

The patient's wife was also unaware that she could have visited him in the Trust's mortuary despite this information being provided in a leaflet; she felt that communication to relatives could be improved after the death of a patient.

As a result of the feedback gained through this patient story the Trust changed the waiting area in the Trust's mortuary to make it more comfortable for relatives to use. Work is also taking place by the Trust's End of Life Care Service and the Bereavement Care Team to

ensure improved communication.

Mr Catherall observed that there were a number of opportunities for the patient to be taken home with help from carers and social service, but his wife was repeatedly advised against this option. He went on to state that the overall health and care system needed to be able to care for patients and carers within their family and according to their wishes.

In response to Mr McGee's question regarding the actions being undertaken within the Trust to equip staff with the necessary skills to communicate effectively with patients and their family members, Mrs Pearson confirmed that these matters were being considered as part of the wider people strategy and compassionate leadership work.

RESOLVED: **Directors received the Patient Story and noted its contents.**

Mrs Pearson will provide an update on the work being undertaken/ included in the People Strategy to equip staff with the necessary skills to communicate effectively with patients and their family members

TB/2019/090 CORPORATE RISK REGISTER (CRR)

Miss Iddon referred Directors to the previously circulated document and provided an overview of the proposed changes to the register, particularly the inclusion of two risks and the de-escalation of a further two risks. The risks considered for inclusion on the risk register were: *Risk ID 8060*: *Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite* (risk score of 15) and *Risk ID 6190: Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale* (risk score of 16). Directors noted the intention to incorporate Risk ID 8060 into the existing aggregated *Risk ID 8061: Management of Holding Lists*.

The risks that were considered for removal from the risk register were noted to be: *Risk ID 7583: Loss of facility for Level 3 Containment in pathology,* and *Risk ID 7330: Aggregated Risk - Inability to identify, track & monitor the cohorts of women and new-borns who require and have screening due to lack of an end-to-end IT System for Maternity.* As a result of mitigation the risk score for both risks was reduced to 10.

Directors discussed the risks highlighted for inclusion or removal and agreed to include/remove the risks as recommended.

Mr Smyth commented that all the actions relating to *Risk ID 1810: Aggregated Risk - Failure to adequately manage the Emergency Capacity and Flow system* had either been completed or due for completion and as such the only gap in assurance related to the unpredictability of

the number of patients utilising the emergency care pathway. He went on to ask whether Executive colleagues had sufficient confidence in the systems in place to meet the target date for completion in September 2019 or whether this timeframe required revision. He commented that the report in its current format did not provide the required levels of assurance and suggested that an indicator of previous performance and the progress of actions to mitigate and manage the risks would enable the Executive and Non-Executive Directors to gain sufficient assurance.

Mrs Gilligan agreed to review and revise Risk ID 1810 in advance of the next report to the Board. She went on to comment that the report should be read in conjunction with the Integrated Performance Report and the improvements that had been seen over the previous few months.

Mr McGee raised a wider point in relation to the validity of the Corporate Risk Register, in that the document reflects a point in time in terms of the key risks and issues faced by the organisation and went on to suggest that the document could be revised to enable more live reporting.

Professor Fairhurst asked the Executive Directors to consider whether the document was fit for purpose and allowed the Board to easily track the risks that have been identified.

RESOLVED: **Directors approved the proposed revisions to the register.**
Executive Directors will consider whether the document is fit for purpose and allows the Board to easily track the risks that have been identified and gain assurance.

TB/2019/091 BOARD ASSURANCE FRAMEWORK

Miss Iddon presented the document to Directors and confirmed that it had been updated and reviewed by the Finance and Performance Committee and the Quality Committee prior to submission to the Board for review and approval.

Miss Iddon confirmed that there had been a series of discussion by the Committees in relation to the scoring of BAF risk 2 (workforce) and the possibility of raising the score from 20 to 25 based on the increase in the likelihood score to 5. The outcome of the discussions by the Committees was that the scoring of the consequence should be reduced to 4 and the scoring of the likelihood should be increased to 5, which would mean that there was no change to the overall score. The Committees had recognised that the ongoing workforce related risks, particularly in relation to the national pension taxation changes, would have an impact on the capacity within the Trust.

Mrs Quinn reported that plans for mitigation relating to the pensions issue were being developed and a national announcement was being awaited before they could be implemented.

Directors approved the revisions and updates to the BAF.

RESOLVED: **Directors received, discussed and approved the revised Board Assurance Framework.**

An update on the national pension issue and mitigation at national, regional and local level will be provided to the next Board meeting.

TB/2019/092 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Miss Iddon noted that there had been 34 serious incidents reported since the last report to the Board and, of those, 19 were reported through the Strategic Executive Information System (StEIS), with the remainder being managed through the divisional processes. Miss Iddon confirmed that the Trust has a good culture of reporting incidents and often 'over reported' incidents through the StEIS system, only for them to be de-escalated from the system, following investigation. Directors noted the three main categories of incidents were falls, pressure ulcers and delays or problems with diagnosis, and that groups were already in place to address the issues around falls and pressure ulcers which report to the Board via the Quality Committee.

Miss Iddon confirmed that there had been no Never Events in the reporting period but there had been three instances of Duty of Candour not being completed within the required 10 days.

Professor Thomas commented that despite there being a significant number of pressure ulcers reported very few were attributed to the Trust. He went on to state that it was noticeable that the interventions put in place by the Trust had stopped patients coming to harm by getting a pressure ulcer.

Directors received the report and noted its content.

RESOLVED: **Directors received the report and noted its content.**

TB/2019/093 INTEGRATED PERFORMANCE REPORT

Dr Riley introduced the report to the Directors and confirmed that the report related to the period covering April and May 2019. Dr Riley noted the significant pressures facing some areas in the Trust, but also the positive achievements in others; one such example provided

was the Trust once again achieving its 62 day treatment targets for cancer patients.

a) Safe

Miss Iddon reported that accrued mortality figures, reported using the Standardised Mortality Index, had continued to fall over the preceding months. She advised there had been a recent change to the manner in which mortality data is analysed, as it was now done from patient admission rather than 30 days from discharge.

Despite this positive news, Miss Iddon noted there had been a higher number of reported deaths from specific causes than would normally have been expected. This included, septicaemia, which had already triggered an alert from the CQC earlier in the year. Miss Iddon provided re-assurance that a robust action plan had been developed to address this, including a reinvigoration of the sepsis taskforce and a planned relaunch of the Trust sepsis bundle later in the year. Miss Iddon reported that other groups which were close to alerting were being actively monitored by the Mortality Steering Group. No further learning disability deaths had been reported and Miss Iddon advised that the Learning Disability Mortality Review panel was continuing to meet to review cases as needed. Miss Iddon advised that capacity to complete Structured Judgement Reviews had improved significantly from the previous months, with the backlog of cases from previous years now cleared.

Professor Fairhurst invited comments and feedback from Directors and explained the intention behind the new format of the report was to provide a clearer idea of variation for each category, normal or otherwise, and to better indicate whether progress was being made in relation to particular matters. Dr Riley stated he felt the inclusion of the Statistical Process Control (SPC) charts in the body of the report had been a great help to the Executive team and made it a lot easier to spot positive or negative trends. Mr Barnes echoed the positive feedback but, suggested that it may be helpful for additional training to be provided to him and his Non-Executive colleagues to give them a better understanding of the new reporting format. Mr Wharfe agreed the new format had initially been presented at the Finance & Performance Committee and agreed that it was a step in the right direction. Mr McGee explained the new format would be a vital step on the Trust's journey to achieving the CQC rating of 'Outstanding' and noted the continued improvement in mortality figures. Mr McGee also advised that the Trust had been providing support to other organisations in the region with cancer treatments, making its ability to continue hitting its cancer treatment targets even more impressive. Mr Catherall raised a query as to why some categories were classified as deteriorating when they were successfully achieving their targets. Dr Riley

clarified that it was not necessary to look at variation for every indicator, as long as the assurance clearly showed the Trust was consistently hitting or exceeding its targets.

Mrs Pearson drew the Board's attention to the staffing issues detailed on page 14 of the report, explaining that, although the figures for care staff implied a deteriorating position, this was slightly misleading as the Trust was now much closer to its required staffing levels than in previous years, when it had typically been over target. Mrs Pearson advised that care staff at night were still showing as over target, but explained that that this was generally due to additional staff being required to provide 1:1 support to patients. Mrs Pearson reported the fill rate for staff had generally improved over the previous months, but advised that several areas had been under the 80% fill rate due to the lack of co-ordinators. Mrs Pearson requested that the Board note the ongoing work being done with Health Education England (HEE) and the Global Learners Programme to recruit overseas nursing staff and reported that 15 nurses had now arrived from Southern India to begin work in the Trust. Mrs Pearson reported that further 27 nurses were due to join the Trust before September and stated that she felt the process had been a huge success.

RESOLVED: **Directors noted the information provided under the Safe section of the Integrated Performance Report.**

Additional training to be provided to Non-Executive Board members to enable a better understanding of the new reporting format.

b) Caring

Mrs Pearson reported positive news regarding patient feedback, drawing particular attention to the 99% score achieved by the Trust for the Inpatient Friends and Family indicator. Other areas were mentioned as needing improvement, such as A&E, but Mrs Pearson explained this was due to low response rates rather than poor feedback and that work was underway to improve this. The total number of complaints received by the Trust had fallen and Mrs Pearson praised the efforts made by the divisions to achieve this. Professor Fairhurst agreed that this was a major achievement and requested the Board to note the consistent work done over the recent years to deal with complaints more quickly and effectively.

RESOLVED: **Directors noted the information provided under the Caring section of the Integrated Performance Report.**

c) Effective

Miss Iddon confirmed that the Trust had now reached 11 months with no Never Events being reported. 3 clostridium difficile infections were recorded in April, taking the overall numbers for the year to 9, which Miss Iddon explained was well within the overall target of 51. Miss Iddon advised the only challenging area was in relation to other bacteraemia, specifically E.coli and Klebsiella species. Miss Iddon advised there was no planned trajectory in place for E.coli infections and that the sepsis taskforce would be overseeing efforts to achieve the government initiative to reduce infection numbers by 50% by 2021. Miss Iddon further advised the ongoing care required for Klebsiella infections would be provided by the infection control team.

RESOLVED: **Directors noted the information provided under the Effective section of the Integrated Performance Report.**

d) Responsive

Mrs Gilligan reported that A&E performance had continued to improve throughout June and was overall heading in a positive direction. The number of 12 hour trolley breaches had dropped in May and work was ongoing with partner organisations to address waiting times for mental health patients to reduce this even further. Mrs Gilligan reported on areas of challenge and notified members that the Trust had not achieved its Referral to Treatment (RTT) target for May and was unlikely to achieve it in June. Dr Riley advised that the Trust had been asked to participate in a trial of new RTT targets and they were likely to be focused on average waiting times. Dr Riley clarified the new targets were due to be in place by April 2020 and stated that he felt it was good for the Trust to be involved in shaping the national policy.

Mrs Gilligan reported that the Trust had also struggled to achieve some of its cancer targets, particularly breast symptomatic which had only achieved 72.7% against a target of 93%. Mrs Gilligan explained this was due in large part due to some patients choosing not to receive treatment within the 10 day window offered and advised that work was underway with the Commissioners to encourage uptake of treatment within the 10 day period. Similar deterioration was reported for diagnostic waiting times, which had steadily increased over recent months due to challenges within endoscopy and cardiology. Mrs Gilligan provided assurances that the issues within cardiology, relating to echocardiography scans, had now been addressed and no breaches had been reported for April or May.

Miss Malik queried if any of the reported breaches for mental health patients had exceeded 12 hours. Mrs Gilligan confirmed that several had done so, with one patient having to wait for

48 hours before being admitted to a ward, but stated she felt the system as a whole was working far more effectively than it had done in the past. Miss Malik also enquired if the ongoing dispute around pensions had affected the Trust's ability to meet its targets. Mrs Gilligan admitted that many specialties that had previously not had any difficulties achieving their RTT targets were now struggling due to a drop in the numbers of capacity clinics being offered by consultants.

Mr Catherall requested more detail on the reasons given for patients choosing not to be seen within 10 days for cancer appointments. Mrs Gilligan clarified a variety of reasons were typically provided, but that main cause was due to patients assuming there was no cause for concern. Miss Iddon noted that in cases where patients are clearly told that there is a suspicion of cancer they would usually attend 100% of the time.

RESOLVED: **Directors noted the information provided under the Responsive section of the Integrated Performance Report.**

e) Well-Led

Mr Quinn reported a slight improvement in sickness levels but advised that it continued to be a significant challenge. She explained that a pattern had emerged after analysis of the data from previous years and that there would likely be a steady increase in sickness levels over the coming months up to November, with August in particular expected to be a challenging month. In an attempt to alleviate these issues, Mrs Quinn reported a dedicated team was now in place within the HR division to support managers to manage sickness and that a business case was due to be presented for approval which would enable occupational health to provide earlier assistance for any mental health issues. Mrs Quinn also reported that she and her colleagues were now able to utilise live workforce data, using the PowerBI system, and this had enabled easier identification of any hotspot areas for staff to focus on. Mrs Quinn advised the culture work done in theatres had been a success, with a large reduction in overall sickness levels being reported. Mrs Quinn confirmed similar efforts were ongoing to address the numbers of vacancies in the Trust, as this had stayed fairly constant over the years. Mrs Quinn explained a large part of this work was the development of a more innovative recruitment and retention strategy.

Mrs Quinn reported that agency and bank staffing costs continued to be a challenge and that a number of avenues were being pursued to reduce them, including a planned full rollout of the e-rostering system across the Trust. In addition to this, a bank and agency collaborative had been formed with partner organisations across the region and Mrs Quinn advised that a

paper was due to be presented to the Executive team at a later date which would encourage even closer collaboration going forward. Mrs Quinn concluded her report by noting that appraisal compliance was below the threshold and advising that HR business partners were working closely with the Divisions to understand why this area in particular was consistently under target, as this was not the case for other core skills.

Mrs Gilligan praised the development of the PowerBI dashboard, and reported that it had been extremely well received by colleagues within the Divisions as it allowed real-time management of any issues.

Mr Catherall also took the opportunity to praise the content of the corporate induction that he had participated in the previous week and commended the trainers for their extensive knowledge.

RESOLVED: **Directors noted the information provided under the Well-Led section of the Integrated Performance Report.**

f) Finance

Mr Wood reported that the Trust was still on track to achieve its agreed control total as of month 2 of the financial year. Mr Wood advised there were three areas of concern to be considered for future months, namely SRCP, expenditure pressures and income targets. Mr Wood explained the ongoing pension dispute would likely have a significant negative impact and advised that he and his colleagues are doing their utmost to mitigate this.

RESOLVED: **Directors noted the information provided under the Finance section of the Integrated Performance Report.**

TB/2019/094 RAISING CONCERNS ANNUAL REPORT

Mrs Quinn introduced the report, explaining that a significant amount of work had gone into developing the role of the Staff Guardian following Mrs Butcher's appointment in 2017. Mrs Quinn reported that Mrs Butcher performed monthly walkabouts on all sites and had successfully established close working relationships with staff and HR business partners. Mrs Quinn explained that to support the work done to date, a new early resolution policy had been introduced to replace the existing Bullying, Harassment and Grievance Policies. Mrs Quinn confirmed that the new policy had proven to be very successful and that the Trust had won an award from the HSJ for its work in supporting staff culture.

Mrs Quinn presented the figures from the previous 12 months, advising that 185 concerns had been raised to Mrs Butcher, an increase of 26% from the previous year. Mrs Quinn

explained that although this could be considered a cause for alarm if taken at face value, she felt it was a positive development, as it implied that staff felt more comfortable coming forward with any concerns. Of the concerns raised, the majority were attributed to perceived bullying by managers or colleagues and Mrs Quinn advised that all cases had been successfully de-escalated through the early resolution process. A reduction in the time taken to address grievances, from 71 days to 15, was also reported. Mrs Quinn reported that the Trust had been approached by Plymouth University, Sheffield Hallam and the University of Central Lancashire to evaluate the early resolution approach and that discussions were taking place with the Advisory, Conciliation and Arbitration Service (ACAS) around potential funding arrangements. The CQC had also approached the Trust to express interest in adopting the early resolution approach and to share it with other Trusts nationally.

Miss Malik enquired, as the Trust no longer had a formal bullying policy, whether it would still be able to demonstrate, if put before a tribunal, that the correct structures were in place in the event of a member of staff being dismissed. Mrs Butcher explained that the early resolution policy was still based around the same steps as the old policies, but that it had an increased focus on resolving issues before they escalated to formal proceedings.

Mr Hodgson praised the work done and enquired if it would be possible to make a direct correlation with the staff survey results to clearly demonstrate the impact of the new resolution policy. Mrs Quinn explained that as the policy had only been formally implemented in January it would not be possible to make the link this year, but advised that the impact should become more apparent in the following year's results.

Mr Smyth agreed that the numbers presented indicated the policy had been a success and enquired if there were any tools available to benchmark the Trust's performance against other organisations. Mrs Butcher explained that national figures were reported on a quarterly basis and that the Trust was one of the top in the country regarding staff 'Speaking out'.

Mrs Hughes stated it was clear that Mrs Butchers role had made a significant difference, but that she felt the report produced only told half of the story and offered to assist with ensuring all relevant information was included. Mrs Quinn advised a more comprehensive annual report was presented at the most recent meeting of the Quality Committee and suggested this could be utilised.

Miss Malik enquired if additional resources needed to be dedicated to the Staff Guardian function, as Mrs Butcher was still the only lead and the numbers of incidents reported each year were continuing to rise. Mrs Quinn stated this had already been discussed and that several options were being explored to provide Mrs Butcher with any additional support

which was required to continue to deliver the same standard of service.

Mr McGee stated it was important not to underestimate the success of the resolution policy or the importance of ensuring appropriate recognition was given to the Trust for developing it, especially if it was to be rolled out on a national basis.

Professor Fairhurst enquired if the themes detailed in Mrs Butcher's report were what she would have expected and whether there were any outliers. Mrs Butcher explained that there were not significant outliers and that many of the same themes tended to crop up across all areas. Professor Fairhurst congratulated Mrs Butcher and her colleagues on everything they had achieved thus far, especially considering the demanding nature of the work involved.

RESOLVED: **Directors received the presentation and noted its contents.**

TB/2019/095 **SEVEN DAY SERVICES UPDATE**

Dr Riley presented the report on behalf of Dr Dean, and explained that the Trust was required to present it twice a year to the Board to demonstrate how it was complying with the priority clinical standards of NHS England 7 day working. Compared to previous years, an improvement was reported for Standard 2 in both medicine and surgery, despite the Trust still not achieving the 90% target set by NHS England. Dr Riley explained that the team had been asked to gauge performance against other indicators such as length of stay, mortality and the numbers of complaints received on wards, as it was felt this would be more useful than simply labelling areas as 'pass' or 'fail'. Dr Riley reported that although some areas were not hitting the 90% target it had been demonstrated, through the other metrics being measured, that there had been no adverse effect on mortality. This provided some assurance that patient care was not being negatively impacted. Dr Riley explained that, since introduction, there had been a shift in the way patients were seen upon admission and that as a result, the first assessment by a consultant was also not factored into the figures. The Trust was reported as partially achieving standard 8, with twice daily reviews taking place on high dependency areas, and work was ongoing to improve recording of any patients not requiring review over the weekends. Dr Riley also reported surgical rotas would be increasing in the autumn, with twice daily reviews of patients planned on the surgical triage unit.

Professor Fairhurst stated she felt it was important to note that no harm had come to patients, despite some areas not achieving the 90% target. This provided assurance they were being assessed in an appropriate manner.

RESOLVED: **Directors received the report and noted its contents**

TB/2019/096 PEOPLE STRATEGY/ CREATING SUPPORTIVE STAFF CULTURE

Mrs Quinn presented the draft People Strategy to the Board, explaining that the Trust had been asked to develop a robust strategy following work done as part of the Culture and Leadership programme. Mrs Quinn further explained that the paper would form a crucial part of the ongoing design and delivery of objectives to support the Culture and Leadership programme and that care had been taken to ensure that it reflected the direction laid out in the NHS Long Term Plan. Mrs Quinn advised that the paper would also reflect the work already done with partners across the region and would incorporate elements of the existing workforce transformation and health and wellbeing strategies. Mrs Quinn reported that there were still significant challenges that the strategy was intended to try and address, such as high numbers of clinical vacancies, workforce demographics, high sickness and absence figures and the continuing over-reliance on bank and agency staff. Mrs Quinn explained that to facilitate this, six key people priorities had been devised and provided a brief summary of each. Mrs Quinn further explained that detailed work plans for each priority would be developed via the 'Big Conversation' events taking place throughout the year.

Mr Barnes stated that he welcomed the work being done on the strategy and that he was happy to lend his support to it. He suggested that it would be helpful to have a larger focus on training and development in order to develop and progress colleagues through the Trust.

Mr Wedgeworth enquired if there was any way the Trust could influence developments outside the sector. Mrs Quinn responded that a range of actions had already been agreed with the voluntary sector and that some influence was exercised via regulated care homes, but that there would need to be a unified workforce strategy developed for the public and private sectors to coordinate effectively.

Mr McGee noted the proposals detailed by Mrs Quinn were highly ambitious and urged the need to consider the resources that would be required to progress them. He requested that when the strategy was brought back for further discussion at the Board at a future meeting, it was done so in the context of the costs involved.

Professor Fairhurst stated that she supported the recommendations laid out in the report, but agreed with Mr McGee on the need for more information on the resources and arrangements needed.

RESOLVED: **Directors received the report and gave their support to the recommendations contained within it.**

A report will be provided to the next available Board meeting

about the resources needed to implement the strategy.

TB/2019/097 ANNUAL AUDIT LETTER

Mr Wood referred Directors to the document and confirmed that it had previously been presented to and discussed by the Audit Committee members. Directors noted that the letter provided confirmation of the external auditors' review of the Trust's performance in relation to the 2018/19 financial year and had reported an unqualified opinion.

RESOLVED: Directors received the report and noted its content.

TB/2019/098 AUDIT COMMITTEE UPDATE REPORT

Mr Smyth presented the report to Directors for information and highlighted the discussions which had taken place at the last meetings, particularly the positive relationships between the various Trust teams and external and internal auditors.

RESOLVED: Directors received the report and noted its content.

TB/2019/099 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe referred Directors to the previously circulated report and highlighted the discussions that had been undertaken in relation to the revised Integrated Performance Report and approval of the Trust's financial control total. Directors noted the discussions that had been undertaken by the Committee in relation to the review of the Safely Releasing Costs Programme (SRCP) schemes. Mr Wharfe reported that the Committee members had requested that additional assurance be provided at the next meeting concerning the revision of SRCP schemes and the development of new schemes to meet the £4,000,000 gap.

Mr Wharfe went on to confirm that the Committee members have had a brief discussion about the shortage of capital at national level and the need to be cognisant of the potential impact on the Trust's plans.

RESOLVED: Directors received the report and noted its content.

TB/2019/100 QUALITY COMMITTEE UPDATE REPORT

Miss Malik referred Directors to the previously circulated report and, as she had not been present at the meeting being reported, invited other Committee members to highlight any specific issues from the Committee. Directors accepted the report as presented.

RESOLVED: Directors received the report and noted its contents.

TB/2019/101 REMUNERATION COMMITTEE INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2019/102 TRUST BOARD PART TWO INFORMATION REPORT

The report was presented to the Board for information.

RESOLVED: Directors received the report and noted its contents.

TB/2019/103 ANY OTHER BUSINESS

Professor Fairhurst thanked Mr Wood on behalf of the Board for his service to the Trust during his years with the organisation. She went on to wish him well in his new position of Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust.

TB/2019/104 OPEN FORUM

There were no further comments or questions from members of the public.

TB/2019/105 BOARD PERFORMANCE AND REFLECTION

Professor Fairhurst sought the views of the Board members in relation to the meeting. Miss Malik commented that those attendees who had presented papers to the Board for the first time had done a commendable job.

Directors agreed that there were several good examples of how senior leaders and departments within the Trust have worked with staff groups in the development of the People Sstrategy.

RESOLVED: Directors noted the feedback provided.

TB/2019/106 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 11 September 2019, 13:00, Seminar Room 6, Learning Centre, Royal Blackburn Teaching Hospital.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 113

11 September 2019

Purpose Information

Title	Action Matrix
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The outstanding actions from previous meetings are presented for discussion. Directors are asked to note progress against outstanding items and agree further items as appropriate

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2019/081: Open Forum	Dr Riley will liaise with Mr Todd outside the meeting to discuss the issues raised in relation to access and travel when arranging appointments.	Acting Chief Executive	September 2019	Verbal Report
TB/2019/088: Chief Executive's Report	The Trust will develop a virtual trophy cabinet to show to the wider population the good work that the Trust is doing.	Executive Director of Communications and Engagement	September 2019	Verbal Report
TB/2019/089: Patient Story	Mrs Pearson will provide an update on the work being undertaken/ included in the People Strategy to equip staff with the necessary skills to communicate effectively with patients and their family members	Executive Director of Nursing	September 2019	Verbal Report
TB/2019/090: Corporate Risk Register	Executive Directors will consider whether the document is fit for purpose and allows the Board to easily track the risks that have been identified and gain assurance.	Executive Directors	September 2019	Verbal Report
TB/2019/091: Board Assurance Framework	An update on the national pension issue and mitigation at national, regional and local level will be provided to the next Board meeting.	Executive Director of HR and OD	September 2019	Verbal Report

Item Number	Action	Assigned To	Deadline	Status
TB/2019/093: Integrated Performance Report	**Safe:** Additional training to be provided to Non-Executive Board members to enable a better understanding of the new reporting format	Director of Operations	September 2019	Verbal Report
TB/2019/094: Raising Concerns Annual Report	An update on discussions with Advisory, Conciliation and Arbitration Service (ACAS) around potential funding arrangements for the Trust to evaluate the early resolution approach will be provided to the next Board meeting. An update on the CQC's expression of interest to the Trust concerning adopting the early resolution approach at a national level will be provide at the next Trust Board meeting.	Executive Director of HR and OD Executive Director of HR and OD	September 2019 September 2019	Verbal Report Verbal Report
TB/2019/094: Raising Concerns Annual Report	Mrs Hughes will liaise with Mrs Butcher and assist with ensuring all relevant information was included in future Raising Concerns Annual Reports.	Executive Director of Communications and Engagement	September 2019	Verbal Report
TB/2019/096: People Strategy/ Creating Supportive Staff Culture	A report will be provided to the next available Board meeting about the resources needed to implement the strategy.	Executive Director of HR and OD	November 2019	Agenda Item November 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 115

11 September 2019

Purpose Information

Title	Chief Executive's Report
Author	Mrs E-L Cooke, Senior Communications Manager
Executive sponsor	Mr K McGee, Chief Executive and Dr Damian Riley, Acting Chief Executive

Summary: A summary of national, health economy and internal developments is provided for information.

Recommendation: Members are requested to receive the report and note the information provided.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

CEO Report
September 2019

This report is divided into five sections. Section one details major national headlines, section two reports news from across Pennine Lancashire, and section three notes Trust news and initiatives which are aligned to the Trust's values. The fourth section shows the external communications and engagement interactions with the final section summarising the Chief Executive's diary.

One - National Headlines

Top news reports gathered from NHS England, NHS Improvement, NHS Providers and other reputable news sources.

Improved NHS care for Parkinson's, Multiple Sclerosis and Motor Neurone Disease

NHS experts have joined forces with seven leading charities to improve the care of patients with brain and nerve conditions. The The RightCare Progressive Neurological Conditions Toolkit will support quicker diagnosis and better coordinated care for people with conditions including Multiple Sclerosis, Motor Neurone Disease and Parkinson's. The project will also include rolling out fast-tracked blood tests and consultant appointments over Skype.

It is anticipated that the project will help to avoid up to 2,500 emergency hospital admissions a year for patients with these conditions, and release up to £10 million to fund improved services.

New tech to spot sepsis is saving lives

In a major nationwide push to tackle the life-threatening condition new 'alert and action' technology is being introduced. Algorithms are used to read patients' vital signs and alert medics to worsening conditions that are a warning sign of sepsis.

NHS leaders in Cambridge, Liverpool and Berkshire are now helping the rest of the health service to adopt tools to spot it, which costs 37,000 lives a year and is notoriously difficult to identify. In Liverpool, the hospital's digital system brings together lab results and patient observations into one place to help staff diagnose and treat suspected sepsis, saving up to 200 lives a year.

Calls for A-level students to the NHS

The NHS has been working with universities to offer more than 7,000 extra nursing places in higher education from this September. This forms a part of the NHS Long Term Plan to build a workforce for the future, and is supported by the successful 'We are the NHS' recruitment campaign.

Ruth May, Chief Nursing Officer for England, urged those at a crossroads to join the health service. Explaining that the NHS is a fantastic employer with a huge range of career options available.

Campaign to help patients avoid long hospital stays

The new campaign encourages staff to ask themselves 'Why not home? Why not today?' when planning care for patients recovering from an operation or illness. 'Where Best Next' aims to spare around 140,000 people a year from a hospital stay of three weeks or more.

As well as being better for those individuals who get home with the right support quicker, the drive could also free up more than 7,000 beds for other patients – the equivalent of building an extra 15 large hospitals.

Medicine costs cut by three quarters of a billion pounds

More than £700 million has been saved to be reinvested into new treatment as part of the Long Term Plan. An NHS-wide operation has supported patients and doctors to maximise the use of 'generic' and best value 'biologic' treatments.

A single drug – adalimumab – treatment for arthritis and other diseases, saved £110 million alone thanks to a 'smart procurement', after the drug came off patent at the end of 2018. Previously adalimumab was the individual medicine on which hospitals spend the most, at a cost of more than £400 million a year.

Life-changing drug for people with severe Haemophilia

A new drug – Emicizumab (also referred to as Hemlibra®) – will bolster the blood to avoid uncontrolled bleeding. It will also help to reduce treatment times from multiple infusions every week to a single injection given once-a-week or fortnight.

NHS England has agreed to fund the drug for around 2,000 people in the country who live with the condition. They include many young children whose parents sometimes struggle to administer the current infusion several times a month. The new treatment is part of a package of measures set out in the NHS Long Term Plan which will save lives through access to the most advanced medical interventions.

New Oversight Framework for 2019/20

NHS England and NHS Improvement have launched the NHS Oversight Framework for 2019/20. It replaces the single Oversight Framework and the Improvement Assessment Framework. The new framework provides a focal point for joint work, support and dialogue between NHS England and NHS Improvement, CCGs, providers and sustainability and transformation partnerships, and integrated care systems.

Prevention and public health

The Cabinet Office and the Department of Health and Social Care published the consultation and green paper on prevention and public health: Advancing our health: prevention in the 2020s It argues that people need to view health as an asset to invest in throughout their lives. Outlined in its proposals are more targeted support, tailored lifestyle advice, personalised care and greater protection against future threats. Prevention is crucial in supporting the delivery of the ambitions of the Long Term Plan.

Pension proposals

An announcement by the Department of Health and Social Care regarding pension rules for senior clinicians has been welcomed. Changes will be made to allow senior clinicians to take on extra shifts without losing out financially. The department will shortly publish a new consultation document proposing wide-ranging national flexibilities to the NHS pension scheme.

Prior to the announcement Trust leaders had reported significant numbers of key clinical and managerial staff no longer able afford to work extra shifts and weekends. In some cases this had led to delays in surgery and gaps in rotas having to be covered by costly agency staff.

Ongoing NHS preparations for EU Exit

Although the final outcome of negotiations for the UK to leave the European Union (EU) remain unclear, contingency planning for all eventualities, including a 'no deal' EU exit, are continuing. Patient care and safety will remain a priority.

The Department of Health and Social Care (DHSC) is leading the response to EU Exit across the health and care sector. DHSC is also the key contact for the sector with the Department for Exiting the EU and the Cabinet Office. NHS England and NHS Improvement are working closely with DHSC to best prepare the NHS.

DHSC has produced EU Exit Operational Guidance which outlines the actions that providers and commissioners of health and social care services should take to prepare for, and manage, the risks of a no-deal exit scenario.

Two - Pennine Lancashire Headlines

Important updates and information reflecting work being carried out by the integrated health and care partnership for Pennine Lancashire.

Together a Healthier Future update

Pennine Lancashire Integrated Care Partnership Strategy Development

The Pennine Lancashire Integrated Care Partnership has been undergoing a system refresh over the last few months. The objective of the refresh has been to agree a strategic direction and narrative to move the partnership forward towards a more focussed Population Management Approach and a partnership delivery aligned with the NHS Long Term Plan.

The NHS Long Term Plan, published on 7 January 2019, sets out the ambitions,
Commitments and priorities for the next ten years. The Plan set out six priority areas for change, which are:

- Do things differently through a new service model
- Take more action on prevention and health inequalities
- Improve care quality and outcomes for major conditions
- Ensure that NHS staff get the backing that they need
- Make better use of data and digital technology
- Ensure we get the most out of tax payers money

The Healthier Lancashire and South Cumbria Integrated Care System (ICS) have been working to clarify their priorities, in response to the NHS Long Term Plan and have produced a draft Strategic Narrative setting out their vision for a healthier Lancashire and South Cumbria. The narrative has been developed for system leaders and senior clinical/programme leads, as a forerunner to developing the ICS Strategy (five-year plan).

Whilst the requirements of Integrated Care Partnerships (ICP), feeding into the strategy development process, are not yet clear, the ICS has confirmed it will draw upon the content of ICP plans to develop the strategy. As such, Pennine Lancashire will be required to confirm its priorities and plans and produce technical appendices (financial, demand and capacity, activity and workforce) in line with the national and ICS timescales. Work has commenced locally to

develop a coordinated response to the ICS planning approach and further updates will be provided to ELHT Board members during September.

ICP Strategic Delivery

Our delivery ambitions, identified in The Pennine Plan, were reaffirmed by the Long Term Plan and as such our priority areas of focus remain as follows:

- Primary Care Networks and neighbourhoods are fundamental to the delivery of our vision. We will ensure they have the resources and skills to support people to live in their communities in a way that promotes health, independence and happiness.
- Aligned to neighbourhoods, we will transform intermediate tier services to help people to stay out of hospital and also support people to get back home after spending time in hospital. This will particularly support our growing older population as they become frailer and move closer to the end of their life.
- Our clinical strategy will focus on ensuring our service transformation delivers improved outcomes for people affected by cancer, heart disease, stroke, respiratory and musculoskeletal problems.
- We will engage with individuals and their families, giving them access to the widest range of local services, at the same time, empowering our communities to take more control over their health and wellbeing.
- We will use information relating to individual and community needs to direct our actions and resources, using a population health management approach. This will ensure we focus on improving the long term health and wellbeing of our population and reduce inequalities.
- We recognise to drive the improvement of health outcomes in Pennine Lancashire we must commit any new resources into prevention, PCNs and wider community services, making a ‘shift left’, whilst continuing to maintain the best quality acute and specialist services.
- Our People Strategy will enable us to recruit the best people, with the right skills and values, to a system that supports the workforce to be the best they can be in a culture of community, compassion, inclusion, innovation and improvement to deliver care to the population it serves.

myGP app launched in Blackburn with Darwen

The myGP app will make it easier for residents to book GP appointments, order repeat prescriptions and set up medication reminders. Promoted by all GP practices in the borough, the app is available to download for both Apple and android smartphones.

Healthier Lancashire and South Cumbria has funded the app as part of a shared digital health strategy, 'Our Digital Future'. This new technology will play a vital role in helping provide people more control over their health and care.

Sport England visits together an Active Future

Andy Long, who sits on the Sports England Board, paid a visit to check in on the progress of the Together an Active Future pilot. Back in December 2017 Sport England selected Pennine Lancashire as one of the 12 areas to benefit from a share of £100M of National Lottery funding. Following an opportunity to meet with a group of local people directly benefiting from the funding, Mr Long was very pleased with the commitment, passion and drive for the work being carried out.

New service to support young people to be rolled out

'Kooth' is an anonymous and confidential online counselling and emotional wellbeing service for young people aged 11-16 years. The free to use service launched in April, and is now being rolled out across the whole of Lancashire and South Cumbria. Accessible via mobile phone, tablet or computer, this digital solution will provide flexibility and support where and when they are most needed for the young person.

In addition to the friendly counselling within the service, there are articles written by young people, access to support from the Kooth community and the opportunity for young people to write in a daily journal.

Take up has been fantastic and in the first three-month period, over 800 young people have registered within Lancashire and South Cumbria for the service; there have been 3,061 logins, 306 chat sessions and 1,247 messages received from across the area.

Using data to shine a light - not create heat

The population health management pilot programme has helped improve health outcomes for local people through personalised care interventions. People with mental ill health, frailty, respiratory conditions and housing problems have all been helped by using data in a different way. Dr Sakthi Karunanithi, population health and prevention lead for Lancashire and South Cumbria Integrated Care System has published a blog explaining how.

Kerala government visit

On the 16 July 2019, colleagues from ELHT and Lancashire Teaching Hospitals Trust welcomed ministers and officials from the Government of Kerala, India.

The visits, which had been arranged at the request of the Government of Kerala, were to enable the ministers to meet Kerala Nurses who had been recruited as part of Health Education England's Global Learners Programme.

CancerStats Portal helping to improve cancer outcomes

The CancerStats Portal has been designed to give providers of various types of cancer data rapid, quality feedback on the quality of their submissions. It allows users to look at the completeness of key data items and to conduct comparisons with local, regional and national averages to calculate relative performance.

The Lancashire and South Cumbria Cancer Alliance is using this tool to analyse data for a number of metrics. This allows partners to look at operational performance, prevention, screening, early diagnosis, diagnostics, treatments, outcomes, patients experience and personalised care.

Three - ELHT Headlines

Sponsored by Dr Damian Riley, Acting Chief Executive. Important news and information from around the Trust which supports our vision, values and objects.

Use of the Trust Seal

The Trust seal has been applied to the following documents since the last report to the Board:

- On **6 August 2019** the seal was applied to the Project Proposal Form between the Trust and the ISSA Foundation for medical devices. The funds provided by the ISSA Foundation are for the purchase of medical devices through the Trust's charity (ELHT&Me). The form was signed by Christine Hughes, Executive Director of Communications and Engagement and Michelle Brown, Acting Executive Director of Finance.
- On **30 August 2019** the seal was applied to the Deed of Easement for Underground Service Media between the Trust and McDermott Developments Limited. The deed was signed by Dr Damian Riley, Acting Chief Executive and Mrs Michelle Brown, Acting Executive Director of Finance.
- On **31 July 2019**, Kevin McGee, Chief Executive/Accountable Officer signed the Major Works Project NEC3 ECC Option C Target Contract with Activity Schedule for the stage 4 AMU works at the Royal Blackburn Teaching Hospital site between the Trust, Vinci Construction UK Limited and Sir Robert McAlpine Limited. Mrs Angela Bosnjak-Szekeres, Associate Director of Corporate Governance witnessed the signing of the document. The Trust's seal was not required on this document.

New appointment to Associate Non-Executive Director role

ELHT strengthened its board of directors with the appointment of Harry Catherall as the Trust's newest Associate Non-Executive Director.

Harry brings unrivalled knowledge and a wealth of leadership experience that will prove invaluable as the Trust responds to the significant operational and financial challenges facing NHS organisations and our social care partners.

A 'first ever' for ELHT and RCM

Keelie Barrett has become the first Maternity Support Worker to be elected to the Board of the Royal College of Midwives (RCM). Keelie has worked at ELHT for 10 years, joining maternity services five years ago. As part of the RCM Board, Keelie will help to set the strategy and the vision for the RCM; holding the executive team to account to deliver upon those strategies. This is a great achievement for Keelie and the Trust.

ELHT&Me scores support of Blackburn Rovers Football Club

It was a proud moment when ELHT's official charity – ELHT&Me – was named as one of Blackburn Rovers' chosen charities for the 2019-20 Championship Campaign. Becoming one of the premier league club's chosen charities means that ELHT&Me will host a designated matchday at Ewood Park, organise a joint charity event, and use signed merchandise and match tickets to raise funds.

The charity will also benefit from player appearances and support, along with a named player ambassador, defender Darragh Lenihan. Darragh will help promote charity events and campaigns.

Patient technology innovation scoops national award

The digital revolution benefitting patients and staff at ELHT was recognised at the national Public Sector Paperless Awards 2019. ELHT Directorate Manager for Outpatient Services, Sue Elliston and colleagues collected the **'Best Use of a Digital Solution'** award in recognition of the Trust's successful introduction of new Patient Portal technology.

Not only has the ELHT Patient Portal been a hit with patients, it's also reduced missed appointments, delivered financial savings and helped the environment. In comparison with the previous year, in the last 12 months the Patient Portal has achieved a drop in the Trust's did-not-attend (DNA) appointment rate to 7.5 per cent, significantly lower than the regional average and freeing up 10,000 additional appointments that would have been wasted.

Bright future in hospital services

Nine young adults from across East Lancashire graduated with honours from the latest 'Get Into Hospital' work opportunity programme run by The Prince's Trust in partnership with ELHT. The four-week programme gave the group valuable work experience in finance, catering, patient

services and laundry services. The aim being the new-found skills, knowledge and experience will then help them gain future employment.

The High Sheriff of Lancashire, The Hon Ralph Christopher Assheton TD DL joined ELHT Acting Chief Executive, Professor Damian Riley to present students with certificates at a special graduation ceremony.

'Space' technology first at ELHT

Surgeons at ELHT are the first in the North West to use a hi-tech innovation. This is fantastic news for prostate cancer patients, who now have the opportunity to undergo radiation treatment while minimising potential side effects. Known as SpaceOAR (Organ At Risk), the Hydrogel Spacer is clinically proven to lower radiation exposure to the surrounding organs and tissues.

ELHT is one of only 10 hospitals nationwide chosen to pioneer the SpaceOAR technology for patients with prostate cancer.

A&E retreat room offers a safe haven

Staff working in the Emergency Department at Royal Blackburn Hospital now have access to a private space to reflect and gather their thoughts following traumatic situations or difficult circumstances. The 'Retreat', generously funded by ELHT&Me, provides a quiet space where staff can regain composure, gather their thoughts, and support each other after a difficult experience at work.

In addition, approximately 30 Emergency Department Staff Champions have been recruited. These are staff from a variety of roles and professions - consultants, sisters, staff nurses, health care assistants and administrative staff. All are willing to act as a support to colleagues and discuss any issues in confidence, or just to sit and listen.

Seven tea parties for 71 years

Over the summer months of July and August, staff from across the Trust were honoured with celebratory tea parties to thank them for their continued support and to commemorate the 71st birthday of the NHS.

Fifty staff each - covering a host of roles - from across seven divisions tucked into tasty sandwiches and cakes handmade by the ELHT Catering Team. All while listening to the dulcet tones of local entertainer, Natalie Jacks.

The tea parties were made possible by the support of the Trust's charity, ELHT&Me. Each year, patients, relatives and the local community donate generously to say 'thank you' to our extraordinary staff, who work tirelessly to provide the best for our patients.

Four – Communications and Engagement

A summary of the external communications and engagement activity.

July 2019

Communications and Engagement

Monthly Media Update

Top Stories...

- East Lancs obstetrics training 'best in UK'
- ELHT appoints Harry Catherall as Associate Non-Executive Director
- ELHT achieves rise in research patients
- Indian Minister meets Global Learner Nurses in Blackburn
- Patient technology innovation scoops national award

Maternity Support Worker Keelie first ever to be elected for RCM Board

Press and Media Relations...

36	15	10	83%	+31
Mentions in all media ↓	Media enquiries handled ↑	Media releases issued this month ↓	of stories were positive or neutral ↓	The monthly media net score (positive minus negative

Projects the Communications Department has supported...

- TOGETHER a healthier future
- Well Service events
- NHS Big Tea Parties
- Therapy Dog
- Annual Report
- Phase 6
- Phase 8
- World head and neck cancer day
- Share2Care

Website...

Our website got **103,787** page views by **34,631** people .

The most viewed webpage was – **Shuttle Bus**

Social media and digital...

Followers on social media:

10,489

6,065

1,408

7545.5

Avg Weekly Facebook Reach

272,000

Twitter Impressions

100%

Facebook page responsiveness

713

Twitter mentions

The most talked about issues on our social networks..

- Ice Lollies for Clinical Staff
- Phoning 999 for trivial matters #MaketheRightChoice
- Warm Weather Messages
- Kevin McGee on BBC/ENT Clinic and UCLan Award

Posts of the month...

Facebook review rating:

4.5 out of 5

Routine activity:

Weekly staff bulletin
Team Brief meetings and video
Our Trust Your News
Supporting events with photography
Supporting ELHT&Me

If you would like any further information about this report please email communications@elht.nhs.uk

Safe | Personal | Effective

Safe | Personal | Effective

Communications and Engagement

Monthly Media Update

Top Stories...

- Engineer hailed hero after hospital fire rescue
- Princes Trust programme promises bright future in hospital services
- 'Retreat room' available to A&E staff for wellbeing and support
- ELHT doctor wins excellence award from satisfied patients
- Paw-fect boost for Burnley

East Lancashire Hospitals first to introduce 'Space' technology

Press and Media Relations...

37	8	8	100%	+37
Mentions in all media ↑	Media enquiries handled ↓	Media releases issued this month ↓	of stories were positive or neutral ↓	The monthly media net score (positive minus negative

Projects the Communications Department has supported...

- TOGETHER a healthier future
- Well Service events
- NHS Big Tea Parties
- Therapy Dog
- Annual Report
- Phase 6
- Phase 8
- PLACE
- Dementia Strategy

Website...

Our website got **96,181** page views by **33,016** people .

The most viewed webpage was – **Waiting Times**

Five - Chief Executive's Meetings

Below are a summary of the meetings the Acting Chief Executive has chaired or attended.

August 2019 Meetings

Date	Meeting
1 August	A&E Delivery Board
2 August	L&SC Provider Board
2 August	L&SC Sir David Dalton Workshop
6 August	Clinical Strategic Executive/Operational Executive Briefing
6 August	Engaging Managers
6 August	Chairman update
7 August	Team Brief
7 August	Mental Health System Improvement Board
8 August	Staff Safety Task and Finish Group
8 August	Visit to Peri-Operative Medicine
9 August	Princes Trust Celebration event
13 August	Clinical Strategic Executive/ Operational Executive Briefing
13 August	NHS Tea party
15 August	Finance Assurance Meeting
15 August	Chairman update
15 August	Visit to Laundry and Decontamination Services
19 August	Opening of Emergency Department Retreat Room
19 August	Andrew Crawshaw, NHSI Director of Performance
20 August	Clinical Strategic Executive/Operational Executive Briefing
20 August	Chairman update
21 August	L&SC ICS AOs and CEOs
22 August	Employee of the Month

27 August	Clinical Strategic Executive/Operational Executive Briefing
30 August	Retirement presentation

September 2019 Meetings

Date	Meeting
2 September	Corporate Induction
3 September	Clinical Strategic Executive/Operational Executive Briefing
4 September	Mental Health System Improvement Board
5 September	NHS Expo
9 September	Shadow Trust Board
10 September	Clinical Strategic Executive/Operational Executive Briefing
10 September	Chairman update
11 September	Trust Board
12 September	Foundation Forum
12 September	Staff Safety Task and Finish Group
13 September	Phase 6 Ground Breaking
16 September	PL Financial Sustainability Meeting
17 September	Clinical Strategic Executive/Operational Executive Briefing
17 September	Chairman update
18 September	Waste Reduction Programme Launch
19 September	Finance Assurance Board
20 September	Phase 8 Official Opening
24 September	North West System Leadership Forum
25 September	Annual General Meeting
25 September	Partnership Leaders Forum

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 117

11 September 2019

Purpose Monitoring

Title	Corporate Risk Register
Author	Mr M Stephen, Head of Safety & Risk
Executive sponsor	Dr I Stanley, Medical Director

Summary: This report presents an overview of the Corporate Risk Register (CRR) as of the 9th August 2019 these risks which were reviewed at the Risk Assurance Meeting (RAM) on the 9th August by the Divisions and Corporate services for review, scrutiny, assurance.

Recommendation: Members are requested to receive, review, note and approve this report and to gain assurance that the Trust Corporate Risk Register is robustly reviewed, scrutinised and managed in line with best practice.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

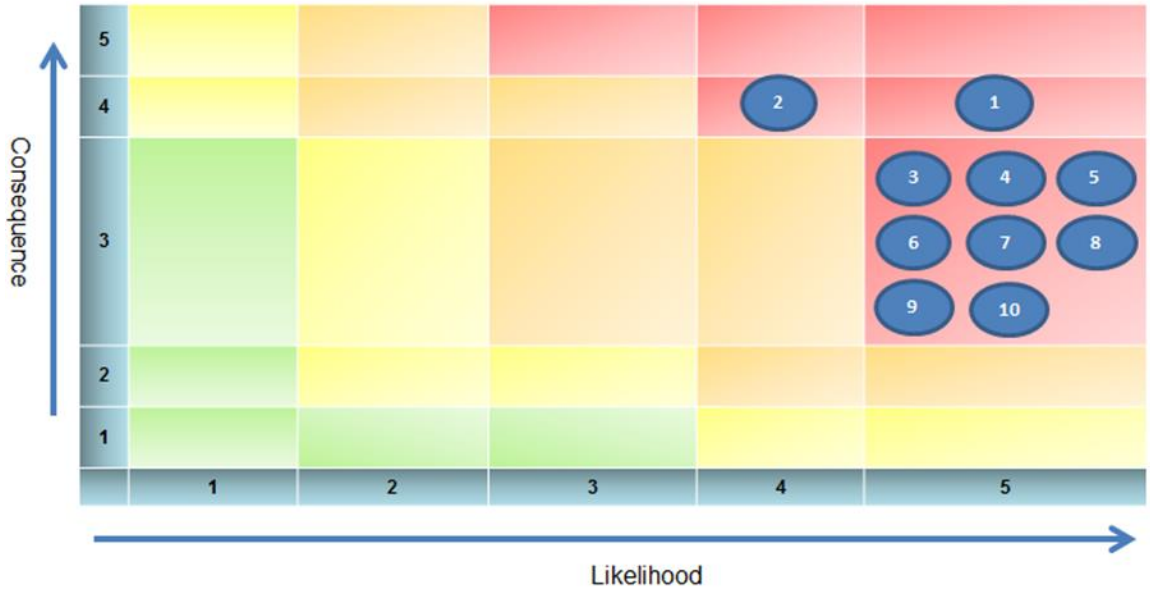
Impact

Legal	No	Financial	Yes
Equality	No	Confidentiality	No

Table 1: The Corporate Risk Register (CRR) as of 30th August 2019

No	Risk	Title	Current Score	Actions ongoing (Lifted from Datix)	Date last reviewed (Lifted from Datix)
1	7010	**Aggregated Risk** - Failure to meet internal and external financial targets in year will adversely impact the continuity of service	20	1 out of 1 action(s) on-going	21/08/2019
2	8061	**Aggregated Risk** - Management of Holding List	16	2 out of 5 action(s) on-going	03/04/2019
3	7067	**Aggregated Risk** - Failure to obtain timely mental health (MH) treatment impacts adversely on patient care, safety and quality	15	7 out of 7 action(s) completed **(New actions under review)**	21/08/2019
4	1810	**Aggregated Risk** - Failure to adequately manage the Emergency Capacity and Flow system.	15	3 out of 18 action(s) ongoing	19/08/2019
5	5791	**Aggregated Risk** - Failure to adequately recruit to substantive nursing and midwifery posts may adversely impact on patient care and finance.	15	1 out of 1 action(s) completed **(New Actions under review)**	21/08/2019
6	5790	**Aggregated risk** – Failure to adequately recruit to substantive medical posts may adversely impact on patient care and finance.	15	4 out of 4 action(s) on-going	30/08/2019
7	7008	Failure to comply with the 62 day cancer waiting time.	15	6 out of 6 action(s) on-going	24/07/2019
8	7552	Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.	15	2 out of 4 action(s) on-going	01/08/2019
9	8060	Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite	15	2 out of 6 action(s) on-going	21/08/2019
10	8126	**Aggregated Risk** - Potential delay in the implementation of Electronic Patient Record (EPR) System	15	2 out of 4 action(s) on-going	21/08/2019

Table 2: CRR Risk Heat map



Change in Risk Template

1. The risk register template has been amended to capture more information which will support the assurance provided to board.
2. A new table for actions that are on-going has been added which shows how many have been completed against what are still ongoing.
   a) Actions within all the risks are progressing and are on-going and their expected completion dates are noted further in the report.
   b) Completed actions have been removed from the report to focus on what is left to do to mitigate the risk.
3. A new column has been added to show when the risk was last reviewed. This information has been taken from Datix, work may have been underway with the risk and will be regularly updated in meetings, work streams related to the risk but not necessarily updated on the system. Risk handlers have been contacted and reminded to update the review dates. Any risk over a score of **(15)** is expected to be reviewed monthly.

Risks recommended for inclusion on the (CRR) in the August (RAM) Risk Assurance Meeting

No	Risk	Title	Current Score
1	6654	Use of surgical day-case unit for escalation when increased demands within the Trust	**15**
2	8160	There is a potential to compromise the quality of care due to poor synchronization and connectivity.	**15**

Table 3: items recommended for the (CRR) in August

1. **Risk 6654 –** This risk was discussed in detail at RAM in August. It was agreed that this risk would be kept at its current score of **(15)** whilst it is under further investigation and escalation. The risk has been linked up to other Incidents and Risks to ensure we are collating all the information together. The risk is to be escalated within divisional committees as well as the Operational Executive Briefing (OEB) on 13th August 2019, agreements have been made within the OEB to trial non-use of the unit and further beds will be available when a currently closed ward re-opens. The risk will be re-reviewed in OEB at the end of September. No agreement has been made to place this on the CRR.
2. **Risk 8160 –** This was discussed at RAM but further investigation work needs to be completed by the Deputy Chief Informatics Officer including re wording of the title and description. Agreed to keep at its current score whilst investigation and re-wording completed, to be discussed at September RAM. The risk is being assessed to if this is a trust wide issue and relates to the use of mobile equipment and laptops and connectivity issues using such devises which can have impact on patient care. No agreement has been made to place this on the CRR as further investigation work continues.

Risks escalated for Executive Review in August (RAM)

1. **Risk 8126 –** *(Potential Delay in the implementation of the Electronic Patient Record (EPR) system).* This risk has been recognised as a growing risk because of the impact it currently has on trust operations due of the lack of

'single system' use. Scoping work has been co-ordinated to review the number of incidents that by not having a single use EPR system in place could have caused, along with a review of the risks current scoring. This has been done in line with trust policy, reviewing evidence within the risk and how it is impacting the trust.

2. **Current Risk Score (15)** Consequence 3, Likelihood 5
3. **Recommended risk score (20)** Consequence 4, Likelihood 5
4. **Recommendation:** The current score does not reflect the issues that are faced in the trust not having a single system of use for patient data. There have been **327** incidents since the start of 2018. **188** incidents have occurred since January 2019. These incidents have been found using the following categories and a contributory factor may be because of the trust not having a sufficient system in place. These categories have been searched because they match up significantly to the risk itself.
5. Categories searched for linked risks:

- Incorrect patient record received
- Records in poor condition
- Records unavailable when needed
- Records untraceable (for Health Records Staff use only)
- Records/documents destroyed inadvertently

a) The recommended score of **(20)** has been made based on the number of risks and incidents aggregated within this particular risk and also the scoring against the 'Descriptors of Consequence' within the Trust Risk Management Strategy. Members are being asked to consider the support of moving the score of this risk to a **(20)**.

Corporate Risk Register (Appendix 1):

1. Details of the current Corporate Risk Register can be found in appendix 1, including the management of actions and controls within the risk. This has been updated with the latest information following the RAM meeting on the 9th August. Outstanding actions have been chased with the relevant handler and controls have been reviewed.

Conclusion

2. Members are requested to:

a) Review, scrutinise and approve the Corporate Risk Register (appendix 1).

b) Gain assurance that risks on the CRR are being robustly managed in line with best practice and the Trust Risk Management Strategy.

c) Support the ongoing management of Corporate Risk Register risks within respected functions/divisions throughout the Trust.

d) The Head of Safety & Risk and Company Secretary will address the concerns raised from the board in the July meeting about the CRR being aligned to the strategic risk management process and this will be reflected in further reports to the board and Quality Committee.

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating**				
Risk ID	7010		Date opened	25/08/2016	
Risk Handler	Allen Graves		Exec Director/Risk Lead	Charlotte Henson	
Identified in BAF Risk ID	BAF/04: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework.				
Linked to Risks:	1487 - Failure to deliver the SRCP- (15) 1489 - Failure to meet the activity and income targets - (12) 6692 - Risk to safe, personal and effective service delivery due to lack of quality information from Community IT systems (EMIS) - (10)				
Initial Rating	**Likelihood: 3 Consequence: 5 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 4 Total: 20**	Target Rating:	**Likelihood: 3 Consequence: 4 Total: 12**
What is the Hazard	• Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the hazard	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust. • Sustainability and Transformational funding would not be available to the Trust. • Cash position would be severely compromised.	
What controls are in place	• Standing Orders. • Standing Financial Instructions • Procurement standard operating practice and procedures • Delegated authority limits at appropriate levels throughout the organisation • Training for budget holders • Availability of guidance on Trust intranet • Monthly reconciliation • Daily review of cash balances • Finance department standard operating procedures and		What are the gaps in controls	• Individuals acting outside control environment in place.	

	segregation of duties		
What assurances are in place	• Variety of financial monitoring reports produced to support planning and performance. • Monthly budget variance undertaken and reported widely. • External audit reports on financial systems and their operation. • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting. • Monthly budget variance report produced and considered by corporate and Trust Board meetings. • Internal audit reports on financial system and their operation.	What are the gaps in assurance	• None identified.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected Completion date	RAG Rating
	1	Risk mitigation action plans are appended to each of the linked risks and are reviewed by the Divisions on an on-going basis with assurances being provided to Divisional meetings.	Allen Graves	27/09/2019	27/09/2019	

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Management of Holding List**				
Risk ID	8061		Date opened	05/02/2019	
Risk Handler	Victoria Bateman		Exec Director/Risk Lead	Natalie Hudson	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations. (Poor patient experience and risk to patient safety).				
Linked to Risks:	6190 - Insufficient Capacity to accommodate the volume of patients requiring to be seen in clinic within the specified timescale (16).				
Initial Rating	**Likelihood: 4 Consequence: 4 Total: 16**	Current Rating:	**Likelihood: 4 Consequence: 4 Total: 16**	Target Rating:	**Likelihood: 2 Consequence: 4 Total: 8**
What is the Hazard	• Patients waiting past their intended date for review appointment and subsequently coming to harm due to a deteriorating condition or suffering complications due to delayed decision making or clinical intervention.		What are the risks associated with the hazard	• At ELHT Directorates utilise holding lists to manage patients who require a future follow appointment but due to capacity constraints, there are not the available slots to book into. Patients are also added to a holding list when clinics are cancelled due to annual or study leave and there is no available capacity to rebook. • Reports are readily available which identify patients waiting on a holding list and how long they have been waiting. They can be seen prospectively and retrospectively. Some of these patients may have comments in their PAS record which identify their urgency but many do not. • In some Directorates due to capacity constraints patients are waiting past their intended date for review. The risk to patients is that they may come to harm due to a deteriorating condition or complications due to delayed decision making or clinical intervention.	

What controls are in place	The following controls have been put into place: • Meeting held between the Divisional Triad and the Ophthalmology Triad to discuss the current risk and agree next steps (Friday 19th Jan). • Escalated concerns to the Executive Team through Exec Part 2 Meeting (Tuesday 23rd Jan). • Request sent to all Directorates requesting all patients on holding lists who expected their appointment before the end of January who do not have a booked appointment to be initially assessed for any potential harm that could have been caused due to the delay to being seen. Suitable RAG ratings need to be applied to all these patients (Wednesday 6th February). Information to be collected in a standardised format. • RAG status for each patient to be added to the comments field on the patient record in OWL to capture current RAG status. This will allow future automated reports to be produced (starting weekend 2nd and 3rd Feb). • Meeting held with the Directorate Managers from all Divisions to understand the position of all Directorate holding lists (Wednesday 30th January and weekly thereafter). • All patients where harm is indicated or flagged Red to be actioned immediately. Directorates to agree plans to manage these patients depending on numbers. • A process has been agreed to ensure all follow up patients in the future are assigned a RAG rating at time of putting them on the holding list. Rolling out new process from 6th February across the Trust. • An automated reporting system is in development to ensure oversight of the risk stratified lists by speciality. • Underlying demand and capacity gaps must be quantified and plans put in place to support these specialities in improving the current position and reduce the reliance on holding lists in the future. • Report being provided weekly to the Executive Team.	What are the gaps in controls	• Patients currently booked into appointments that are not RAG rated will drop into the Holding List if appointments are cancelled and will not have a RAG rating identified. • Patients that are added to the holding list from other sources such as theatres Wards and Med Sec's will currently not have a RAG identified.
What assurance	• All coding sheets being monitored in outpatient clinic to ensure RAG rating completed at time of appointment.	What are the gaps in	• Demand and Capacity gaps within specialities which may result in delayed appointments outside of RAG

s are in place	• All patients to have RAG rating recorded on Outpatient Waiting List. • Automated report produced to show RAG status of patients on holding list and identify any who have not been given a RAG rating. • Failsafe officer appointed in Ophthalmology to track holding list and manage clinical urgency of patients waiting in conjunctions with responsible consultants.	assurance	rating recommendation. • If clinicians do not comply with RAG rating process in clinic this will be captured on the automated report but will need administrative process to be followed to complete retrospective RAG rating following clinic appointment.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	RAG Rating
1	Progress Report and Harm assessment to be provided to Trust Quality Committee	Natalie Hudson	30/04/2019	31/12/2019 Original completion date changed from 30/04/2019 as regular updates are being sent to the Executive Team and bi-monthly to the Quality Committee.	On track
2	Automated holding list report to be integrated in Trust's weekly ops meeting	Natalie Hudson	30/04/2019	31/12/2019 Original completion date changed from 30/04/2019 as new report has been designed and is being circulated weekly to the Directorates.	On track

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Failure to obtain timely Mental Health treatment impacts adversely on patient care, safety and quality.**				
Risk ID	7067		Date opened	06/10/2016	
Risk Handler	Jonathan Smith		Exec Director/Risk Lead	Sharon Gilligan	
Identified in BAF Risk ID	**BAF/03:** Lack of effective engagement within partnership organisations (ICS and ICP) results in failure to work together causing detrimental effect on the health and wellbeing of our communities. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	2161 - Failure to provide sufficient skilled staffing for the needs of Tier 4 patients on the Paediatrics Ward will adversely continue - (12). 7582 -Inability to meet the needs of high risk mental health patients on in patient wards within ICG - (8) (5083 – Linked to 7582 - Failure to have a robust system to assess and manage patients with mental health needs – (8).				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 4 Consequence: 3 Total: 12**
What is the Hazard	• ELHT is not a specialist provider or equipped to provide inpatient mental health services. However, patients with mental health need do present to the Trust and they may require both physical and mental health assessments, treatment and referral to specialist services. • Due to lack of specialist knowledge, this may cause deterioration of the patient. • Staff members generally do not have training in physical interventions and restraint.		What are the risks associated with the hazard	• Breach of statutory targets • Impact on other patient care due to resource use and patients and/or carers perceptions. • Risk of harm to other patients • Impact on staffing (medical and nursing) to monitor/ manage patients with MH needs. • Patient deterioration or failure to Safeguard. • Risk of patient harm to themselves.	
What controls are in place	• Monthly performance monitoring • Monitoring as part of Pennine Lancashire improvement pathway • Monitoring by Lancashire and Cumbria Mental Health Group • Twice weekly review of performance at Executive Team teleconference • Discussion and review at clinical flow meetings four times daily		What are the gaps in controls	• Unplanned demand. • ELCAS only commissioned to provide weekday service. • Limited appropriately trained agency staff available.	

	• Introduction of mental health triage service within ED • Development of mental health Clinical Decision Unit on the RBH site • In family care liaison with ELCAS • Frequent meetings to minimise risk between senior LCFT managers and senior ELHT managers to discuss issues and develop pathways to mitigate risk • Mental Health Shared Care Policy • OOH Escalation pathway for mental health patients • 24hour Band 3 mental health observation staff • Ring fenced assessment beds within LCFT bed base • Triage risk assessment tool in place • Shared documentation LCFT and ED added on risk 29-1-18 • MH triage in place from 5pm to 1am 7 days per week based in department added on risk 29-1-18 • 2 hourly joint board rounds added on risk 29-1-18 • MHDU came into operation on 1st December 2017 to support patients waiting for a mental health bed or requiring further added on risk 29-1-18 assessment		
What assurances are in place	• Appropriate management structures in place to monitor and manage performance. • Appropriate monitoring and escalation processes in place to highlight and mitigate risks. • Ongoing monitoring of patient feedback through a variety of sources. • Escalation of adverse incidents through internal and external governance processes. • Review of performance by Executive Team members on a weekly basis. • Monthly Performance Report to Trust Board. • Appropriate escalation and management policies and procedures are in place and regularly reviewed. • Joint working with external partners on pathways and design improvements. • 12 hour breach monitoring. • Cluster reviews of 12 hour breaches undertaken.	What are the gaps in assurance	• The daily system teleconference between health and social partners was stood down from daily to twice weekly w/c 2-7-18.

	Presented at A and E Delivery board and SIRI (if required). • Every 12 hour breach is incident reported and has a timeline undertaken to identify themes for shared learning. • Themes from timelines/cluster reviews are discussed weekly with commissioners, NHS England and LCFT • SOP in place for management of high risk patients (recently reviewed and up-dated).		

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	ELHT and Pennine Lancashire representation at ICS Mental Health Improvement Board	D Riley	Ongoing	Until service satisfactorily improved	**ongoing**
	2	ELHT and other Acute Trusts developing an agreed Protocol with LCFT to clarify when it is appropriate to admit patients with mental health diagnoses to acute wards	I Stanley C Pearson	September 2019	September 2019, pending CQC approval of draft Standard Operating Procedure	**ongoing**
	3	ELHT leading planning application for temporary building “pod” as an extension to A+E department, suitable for use as Mental Health assessment unit.	T McDonald	December 2019	December 2019	**ongoing**

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Failure to adequately manage the Emergency Capacity and Flow system.**				
Risk ID	1810		Date opened	05/07/2013	
Risk Handler	Jonathan Smith		Exec Director/Risk Lead	Sharon Gilligan	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	908 - The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12). 7587 - There is a risk that patient's in ED at RBH are not always receiving optimal care due to a lack of embedded clinical systems- (12). 7108 - Extreme escalation areas open in response to capacity issues in ICG - (8).				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Lack of bed capacity across the Trust can lead to extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow.		What are the risks associated with the hazard	• Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. • Delay in administration of non-critical medication. • Delays in time critical patient targets (four hour standard, stroke target, sepsis six, and access to early senior review for trauma patients). • Delay in patient assessment. • Potential complaints and litigation. • Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected demands. • Delays in safe and timely transfer of patients.	
What controls are in place	• Daily staff capacity assessment. • Daily Consultant ward rounds. • Opening of Ambulatory Emergency Care Unit for Acute Medicine including frailty patients and rapid chest pain assessment. • Review of the use of the old Ambulatory Emergency Care for Surgery in progress.		What are the gaps in controls	• Trust has no control over the number of attendees accessing ED/UCC services.	

	• Pennine Lancashire and ELHT Winter Plans approved by Pennine Lancashire A&E Delivery Board and ELHT Operational Delivery Board to support safety and timely care and movement of patients. • Introduction of ED & UCC Trigger Tools and Escalation arrangements including actions cards for relevant roles and services linked to Trust Resilience and Escalation Policy and Procedures. • Establishment of specialised flow team. • Bed management teams. • Delayed discharge teams. • Ongoing recruitment. • Ongoing discussion with commissioners for health economy solutions. • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley. • Introduction of Full Capacity Protocol. • Refined 2 hourly patient flow meetings.		
What assurances are in place	• Regular reports to a variety of specialist and Trust wide committees. • Consultant recruitment action plan. • Escalation policy and process. • Monthly reporting as part of Integrated Performance Report. • Weekly reporting at Exec Team. • System Oversight by Pennine Lancashire A+E Delivery Board.	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected Completion date	RAG Rating
1	Numerous actions are incorporated within the Emergency Care Pathway Redesign Programme which forms part of the Trust's Transformation Programme.	Jonathan Smith	01/09/2019	01/09/2019	On track

	2	Development of Ambulatory and Emergency Care Unit and new pathways.	Jonathan Smith	01/09/2019	01/09/2019	On track
	3	Mitigating actions are deployed on a daily basis at an operational level to reduce the risk to patient care.	Jonathan Smith	01/09/2019	01/09/2019	On track

Title	**Aggregated risk: Failure to adequately recruit to substantive nursing posts may adversely impact on patient care and Finance.**				
Risk ID	5791		Date opened	11/09/15	
Risk Handler	Julie Molyneaux		Exec Director/Risk Lead	Christine Pearson	
Identified in BAF Risk ID	**BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives. **BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.				
Linked to Risks:	3804 - Failure to recruit and retain nursing staff across inpatient wards and departments may result in inadequate nurse staffing - (12) 7496 - There is a risk of failing to deliver financial balance against the ICG nursing budget - (15)				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 3** **Consequence: 2** **Total: 6**
What is the Hazard	• Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the hazard	• Breach of agency cap • Agency costs jeopardising budget management	
What controls are in place	• Daily staff teleconference • Reallocation of staff to address deficits in skills/numbers • Ongoing reviews of ward staffing levels and numbers at a corporate level • Daily review of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels and Care Hours per Patient Day (CHPPD) • E-rostering KPI's • Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage • Monthly financial reporting		What are the gaps in controls	• Unplanned short notice leave and sickness. • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	
What assurances are in place	• Daily staffing teleconference with Divisional Director of Nursing • 6 monthly formal audit of staffing needs to acuity of		What are the gaps in assurance	• None identified.	

	patients • Formal review of nursing and midwifery establishments annually more often if required • Exercise of professional judgment on a daily basis to allocate staff appropriately, alongside Safe Care acuity data • Monthly integrated performance report contains staffing data containing planned to actual nurse staffing levels and CHPPD • Active progression of recruitment programmes in identified areas.		

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1.	Ongoing recruitment, locally, nationally and internationally	Julie Molyneaux	Review monthly	Ongoing review. However will formally review alongside professional judgment review: **28.2.2020**	**On track**
	2.	Workforce transformation: Registered Nurse Associates	Julie Molyneaux	28.2.2020	Ongoing evaluation of programme. Will formally review alongside professional judgment review: **28.2.2020**	**On track**
	3.	Increase to student nurse and midwifery student placements from September 2019	Julie Molyneaux	31.3.2020	Evaluation of increase to student nurses will not be apparent for the next 3 years. However the increase achieved will be assessed: **31.3.2020**	**On track**
	4.	Twice yearly professional judgment review of nurse and midwifery staffing requirements	Julie Molyneaux	28.2.2020	**28.2.2020**	**On track**

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Title	**Aggregated risk: Failure to adequately recruit to substantive medical posts may adversely impact on patient care and Finance.**				
Risk ID	5790	Date opened	11/09/15		
Risk Handler	Emma Davies	Exec Director/Risk Lead	Damian Riley		
Identified in BAF Risk ID	**BAF/02:** Recruitment and workforce planning fail to deliver the Trust objectives. **BAF/04:** The Trust fails to achieve a sustainable financial position and appropriate financial risk rating with the Single Oversight Framework. **BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations.				
Linked to Risks:	7268 - Clinical, financial and organisational risks of (SOS) and T&O short and long term rota gaps – (9). 3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care - (9). 7401- There is a risk that patients may not receive timely clinical care due to a lack of junior doctor cover on medical wards in ICG - (8). 7816 - Medical (psychiatric) waiting list (15). 4488 -Inadequate Senior Doctor Cover for MFOP (6) 5557-Adequate Medical Staffing (12) 908 – The inability to provide performance and patient care due to low medical staffing levels within the ED department – (12) – is linked but wasn't included within this report.				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust. • Difficulties to recruit to some substantive Medical posts e.g. ENT & Ophthalmology.		What are the risks associated with the hazard	• Escalating costs for locums. • Breach of agency cap. • Unplanned expenditure. • Need to find savings from elsewhere in budgets. • Impact on staff stress and wellbeing.	
What controls are in place	• Gaps in rota where junior doctors are required have been identified and we are looking to over recruit where possible. • Academic Clinical Fellow post has been recruited to. • To evaluate using an app our internal bank to ensure our rates are competitive.		What are the gaps in controls	• Reduction in agency staffing costs form previous year has already been demonstrated, however, the availability of medical staff to fill permanent posts continues in some areas, linked to regional or national shortages in some specialties.	

	• HR metrics to be reviewed and used in making forward planning for workforce replacement as well as link the metrics to workforce transformation. • Divisional Director signs off for locum usage. • Ongoing advertisement of medical vacancies. • Consultant crosses cover at times of need. • Development of alternate roles. • Offer of OH support if felt needed. • Retire and Return Policy		
What assurances are in place	• Directorate action plans to recruit to vacancies. • Reviews of action plans and staffing requirements at Divisional meetings. • Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees. • Reviews of plans and staffing requirements at performance meetings. • Analysis of detailed monthly report through AMG (Agency Monitoring Group). Areas for targeted action understood.	What are the gaps in assurance	• Unexpected operational pressures could further stress an already stressed system.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	RAG Rating
1	Ongoing recruitment and innovative packages offered.	Simon Hill	31/03/2020	31/03/2020	On track
2	Workforce transformation and new models of skill mix.	Simon Hill	31/03/2020	31/03/2020	On track
3	On-going pressure to reduce locum rates.	Simon Hill	31/03/2020	31/03/2020	On track
4	All requests to exceed capped rates to be approved by medical directorate on a case by case basis.	Simon Hill	31/03/2020	31/03/2020	On track

East Lancashire Hospitals NHS Trust

Title	**Failure to comply with the 62 day cancer waiting time.**				
Risk ID	7008		Date opened	01/08/2016	
Risk Handler	William Wood		Exec Director/Risk Lead	Natalie Hudson	
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	3835 - Failure to appoint to vacant oncologist posts is impacting on service delivery and provision of safe, personal, effective care (9) 7513 - Radiology capacity issues would impact on inpatient flow, Referral to Treatment (RTT) and Patient Experience. (9)				
Initial Rating	**Likelihood: 3 Consequence: 3 Total: 9**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Cancer treatment delayed. • Potential to cause clinical harm to a patient if the treatment is delayed. • Damage to Organisational reputation.		What are the risks associated with the hazard	• Trust fails to achieve compliance with the 85% national standard for the cancer 62 day waiting time target. • The Trust is performance managed for failure to comply with cancer waiting time targets - the cancer waiting times are key performance indicators for all NHS providers. • Potential to cause clinical harm to a patient if the treatment is delayed. • There is also a risk to the patient experience and risk of adverse publicity/reputation to the Trust.	
What controls are in place	• ELHT wide Action plan to manage pressures by Specialty Directorate • Weekly PTL meetings in all specialties • Bi weekly 'Hot List' of Cancer Patients at Risk of or already breached is issued to all relevant specialties for review to progress patients where possible. • Weekly Cancer Performance Meeting to review at risk patients and forward plan improvements chaired by exec • Patient Education - use of marketing material to encourage patients to attend		What are the gaps in controls	• Multiple Actions require recruitment of 'difficult to recruit' personnel • Patient choice and compliance is a factor which cannot easily by influenced • ELHT Cancer Action Plan - Issues with ownership in some directorates • Weekly Tumour Site PTL Meetings - Some have better membership than others • Cancer 'Hotlist' - manual record, duplication of day to day tracking, limitations when Data & Performance	

			Manager on leave
What assurances are in place	• Pennine Lancashire Cancer Tactical Group • Cancer Action Plan • Weekly Cancer Performance Meeting • Cancer Alliance Rapid Recovery Team Meeting	What are the gaps in assurance	• None identified

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Capacity review.	William Wood	31/07/2019	31/03/2020	Due dates updated but action on track
	2	Pathway review – New alliance pathway for Prostate, Upper GI, Colorectal and Lung.	William Wood	30/04/2019	31/03/2020 Original completion date changed from 30/04/2019 as the new Upper GI has only just been published and will take some time and cross organisational work, to complete.	Due dates updated but action on track
	3	Investment of Alliance Funding in pathways to improve processes.	William Wood	31/03/2020	31/03/2020	On Track
	4	To implement a new Breach Analysis Process	William Wood	31/05/2019	30/08/2019 Original completion date changed from 31/05/2019 so new SOP could be run through the ELHT Cancer Board for approval prior to ratification at the Policy Council.	Due dates updated but action on track
	5	Creation of a comprehensive Cancer PTL and automated Hot List	William Wood	28/06/2019	30/09/2019	Due dates updated but action on track
	6	To recruit to Oncology Vacancies	William Wood	31/07/2019	27/09/2019	Due dates updated but action on track

East Lancashire Hospitals NHS Trust

Title	**Risk that PACS downtime occurs and brings delay to patient pathways or delays in operating theatre activity.**				
Risk ID	7552	Date opened	25/10/2017		
Risk Handler	Moira Rawcliffe	Exec Director/Risk Lead	Mark Johnson		
Identified in BAF Risk ID	**BAF/05:** The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk of safety & poor patient experience).				
Linked to Risks:	7457- Failure to have PACS operating effectively adversely impacts patient care and performance (12)				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 3 Consequence: 3 Total: 9**
What is the Hazard	• Lack of data available while treating patient could cause harm. • The system is periodically failing / turning over so that images are not available as required. This may be due to PACs or networking issues. • The impact of this for the Orthopaedic team is that clinics are delayed/ overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care. • The impact for theatres is also real and in the past cases have had to be cancelled due to delays and unavailability of appropriate images.	What are the risks associated with the hazard	The risks are: • Trust targets • Delays in patient pathway. • Downtime in clinics and theatres due to periodic system failure. • Poor patient experience having to wait around while backup systems are used. • Some occasions backup systems have failed • Increased complaints. • Concerns re patient in theatre and system going down meaning may have to stop / delay operating. This may cause patient harm. • The impact on the consultants is then the clinic over runs into the afternoon session.		
What controls are in place	• New configuration of PACS allows for significantly more resilience and stability. • New PACS operational board being set up to monitor wider PACs delivery.	What are the gaps in controls	• The above controls can`t stop the system from going down. • The impact of this for the Orthopaedic team is that clinics are delayed or overrunning and patients are waiting longer than required. • On occasion patients have left having not been able to get the necessary information to talk through their appropriate care.		

			• The impact for theatres is also real as cases have had to be cancelled in the past due to delays and unavailability of appropriate images.
What assurances are in place	• Current controls can only reduce the potential impact patients.	What are the gaps in assurance	• Controls are being manually implemented and can`t stop the system from going down.

Actions to be carried out in mitigating this risk

	No	Action	Action Lead	Due date	Expected completion date	RAG Rating
	1	Commission new Sectra PACS system	Tom Newton	31/03/2019	19/09/2019 (Original completion date was 29.03.2019 but was moved to 31.08.2019 and then to 19/09/2019 as project has commenced).	Due dates updated but action on track
	2	VNA Viewer	Tom Newton	30/09/2019	30/09/2019	On track

East Lancashire Hospitals NHS Trust

Title	**Potential to compromise patient care/deliver sub-optimal care on the elective centre & infusion suite**				
Risk ID	8060		Date opened	04/02/2019	
Risk handler	Jarrod Walton-Pollard		Exec Director/Risk Lead	Natalie Hudson	
Identified in BAF Risk ID	BAF 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks or Incidents:	Linked to **18** incidents raised on Datix, dated between 2016 and 2019. Risk 8066- Staff wellbeing and safety on the elective centre (8)				
Initial Rating	**Likelihood: 5** **Consequence: 3** **Total: 15**	Current Rating:	**Likelihood: 5** **Consequence: 3** **Total: 15**	Target Rating:	**Likelihood: 2** **Consequence: 3** **Total: 6**
What is the Hazard	• Nurse-led Elective Centre dealing with patients who are on defined pathways. Occasionally patient's condition deteriorates and therefore, may require specialist medical support. The appropriate support may not be available (particularly out of hours) on the BGH site resulting in a transfer to the RBH site. • There is a lack of appropriate policies that support a nurse led unit. • Although all patients have a designated consultant. There is not always a member of their team available to review patients on the BGH site. • There is a trust wide initiative to transfer as much activity as possible onto the BHG site; this at times results in insufficient/inappropriate equipment especially in the case of extra lists. • Staff maybe unable to appropriately administer medication - in the infusion suite due to lack of policies and other specialist medication which staff aren't familiar with. • Cancellation of surgery due to inappropriate site suitability. • Patient safety and care maybe compromised due to delayed/incorrect treatment		What are the risks associated with the hazard	• Potential serious injury to patients as the team will be unable to care properly for the patients due to lack of skill mix, medications or skills. • Potential loss of income for the Trust as surgery will be cancelled as it would be unsafe to continue on the BGH site. • Potential loss of reputation to the Trust should the patient complain or media sources become aware and report any negative events. • Creation of a 28 day rule if procedure cancelled on the day increasing operational pressures to directorates to meet targets. • Lack of policies, procedures, clinical guidelines and protocols for medical patients • Lack of clinical cover for the routine care of all patients such as prescribing, reviewing if none emergency issues as the RMO service is only contracted to deal with emergency situations. • At times current clinical cover is substandard for centre's needs • Poor site suitability criteria and/or site suitability criteria not being following or interpreted differently.	

	• Potential loss of income if procedures are cancelled.		• Extra lists being moved to BGH due to bed pressures on RBH site. • Elective centre deemed a place of safety despite being nurse led resulting in delays in transfer by the ambulance service resulting in patients not been transferred in a timely manner.
What controls are in place	• RMO service in place for emergency situation out of hours. • Site Suitability Policy is in place • There is an onsite anaesthetist during evenings who can review patients at the request of the nursing staff on the unit. • 24 hour senior nursing cover on the BGH site. • Out of hours duty sister to offer support and advice • Can contract ambulatory care for any medical advice between 08:00 - 20:00 Mon-Fri. • Can contact surgical on call for telephone advice.	What are the gaps in controls	• Out-of hours service is due to change from April 2019. Uncertainty surrounding how this is going to change going forward. • Lack of compliance to Policy. • This is a Nurse-led unit without senior clinical cover.
What assurances are in place	• Incidents are now being mapped to this risk. • Risk is now being regularly monitored, reviewed and scrutinised at appropriate governance meeting.	What are the gaps in assurance	• Lack senior clinical supervision/support for this Elective Centre.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	RAG Rating
1	To create templates for each treatment/medication administered at infusion suite.	Michelle Turner	30/08/2019	30/08/2019	On track
2	To identify suitable clinical cover including specialist medical cover.	Charles Thomson	08/07/2019	08/07/2019 (Date change or completion expected 18/08/2019 when risk is updated)	Due dates updated but action on track
3	All policies to be ratified at Policy Council in September, to enable risk to be de-escalated	Jarrod Walton-Pollard	30/09/2019	30/09/2019	On track

East Lancashire Hospitals NHS Trust

Title	**Aggregated Risk: Potential delay in the implementation of Electronic Patient Record (EPR) System**				
Risk ID	8126	Date opened	02/05/2019		
Risk handler	Mark Johnson	Exec Director/Risk Lead	Mark Johnson		
Identified in BAF Risk ID	BAF 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirement defined in the NHS Constitution and relevant regulations (Risk to safety).				
Linked to Risks:	8165- Current IT systems do not support the collection of the Emergency Care Data Set (15) Linked to possible 327 incidents (Please see the start of this report for info)				
Initial Rating	**Likelihood: 5 Consequence: 3 Total: 15**	Current Rating:	**Likelihood: 5 Consequence: 3 Total: 15**	Target Rating:	**Likelihood: 2 Consequence: 3 Total: 6**
What is the Hazard	• The absence of a Trust Wide Electronic Patient System, the reliance on paper case notes, assessments, prescriptions and the multiple minimally interconnected electronic systems in the Trust. • This risk supersedes previous system specific risks.	What are the risks associated with the hazard	• Inability to effectively share a persons medical record with the treatment and support teams. • Potential increase in prescribing errors due to the absence of a ePMA system. • Inability to effectively monitor patient flow and patient care. • Inability to capture required patient and statutory data sets with contingent solutions causing disruptions to patient care. • Loss of income due to poor capture of patient activity. • Inability for patients to contribute and be informed of their care. • Increased risk of harm due to manual transcription of results and observations. • Reduced clinical decision making and excessive tests due to lack of effective decision support systems. • Significant costs to the organisation due to the storage and retrieval of paper case notes. • Increased costs to the organisation due to the inability to comply with regulatory and dataset requirements (eg		

			CNST). • Increased costs to the organisation due to ineffective monitoring of key clinical conditions and treatments (eg sepsis, pressure ulcers, VTE, infection). • Excessive variation in clinical practice leading to sub optimal outcomes for patients due to the inability to monitor practice and effectively implement care pathways. • Poor clinical care coordination across specialties, primary and secondary care and other outside agencies. • Poor patient outcomes due to ineffective referrals and discharge systems due to paper based systems. • Poor data quality due to transcription errors between clinical systems both internally and externally. • Inability to undertake detailed review of patient care due to paper based data collection systems. • Increased patient risk due to inability to capture certain data sets (such as MSDS). • Inability to integrate with Trusts within and outside of the organisation. • Inability to attract senior clinical and operational leaders due to the Trust using ineffective and aged systems. • Poor practice may not be picked up due to inability to measure outcomes consistently. • Patient may become 'lost in the system' due to inability to track them through the stages of care effectively. • Significant reputational damage due to clinical, operational and financial limitations.
What controls are in place	• Stable PAS system (albeit 25+ years old) • Extramed patient flow system, including capture of nursing docs • ICE system • EMIS system • Winscribe digital dictation system • Windip scanning solution	What are the gaps in controls	• Windip scanning solution not across all specialties and casenote groups. • EMIS system only supports community activity, no significant system in acute setting. • Not all ‘feral’ systems are registered (or known about). • Contracts for current systems being ‘rolled over’ annually cannot identify specific ‘switch over’ dates.

	• Orion Portal • 24/7 system support services • Large medical record department • paper contingencies for data capture • Additional administrative staff as required • All critical systems managed by informatics or services with direct links to Informatics. • Register of non-core systems capturing patient information (feral systems) in place. • Improved infrastructure (including storage) to maintain and manage existing systems.		• Inability to rapidly flex the current system to emerging demands from NHSI / D for additional information. • Limited capital budget to invest in additional hardware / software as clinical requirements develop.
What assurances are in place	• Consistent monitoring of current clinical systems and support via helpdesks and informatics services. • Significant amount of Business Intelligence system data quality and usage reports.	What are the gaps in assurance	• Whilst many reports may be produced the Trust does not always have enough admin or clinical resource to action. • Unable to plan infrastructure as new technologies and clinical techniques develop in isolation from the main ePR.

Actions to be carried out in mitigating this risk

No	Action	Action Lead	Due date	Expected completion date	RAG Rating
1	ICS support and approval for ELHT ePR route	Mark Johnson	31/08/2019	31/08/2019	On track
2	Submission of FBC for approval	Mark Johnson	27/09/2019	27/09/2019	On track

RAG Key:

	Outstanding/Overdue		In progress & on track

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

11 September 2019

Item 118

Purpose Assurance
Approval

Title	Board Assurance Framework (BAF)
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary
Executive sponsor	Dr I Stanley, Acting Medical Director

Summary: The Executive Directors have revised the BAF and examined the controls and assurances, together with any gaps, to establish whether they have changed since the July 2019 Trust Board meeting.

Recommendation: The Board is asked to discuss and approve the recommended changes to the BAF. The Board is asked to discuss and agree the current arrangements for the review of the specific BAF risks by the sub-committees.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by:

Executive Directors

Quality Committee (4 September 2019)

(118) Board Assurance Framework Review

1. The Board Assurance Framework (BAF) brings together in one document all of the relevant information on the risks to the Trust's strategic objectives. By regularly reviewing it, the Trust is in a position to identify whether the BAF remains fit for purpose and whether it provides the Board with real confidence that it is having a thorough oversight of the strategic risks.
2. The effective application of assurance processes in producing and maintaining the BAF is enabling the Board to consider the process of securing the necessary assurance using formal procedures that promote good governance and accountability, whilst gaining a clear and comprehensive understanding of the risks faced by the Trust in pursuing its strategic objectives.
3. The BAF informs the Board about the types of assurance currently obtained, so consideration can be given whether they are effective and efficient and enables the Board to identify areas where the existing controls might be failing and the risks that are more likely to occur as a consequence. The BAF also gives the Board the ability to better focus the existing assurance resources.
4. Some of the BAF risks are considered by both the Quality Committee and Finance and Performance Committee (risks 1, 2, 3 and 5) due to their overarching nature, however each Committee only discusses the risk elements under their specific remits and are aligned to their Terms of Reference. The Board is asked to discuss and agree the continuation of these review arrangements by the sub-committees.

Risk 1: Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.

5. It is proposed that the risk score be **reduced** from 20 (likelihood 5 x consequence 4) to **16 (likelihood 4 x consequence 4)**,
6. The key controls section has been updated to include the following:
   a) The ICP programme is monitored through the Pennine Lancashire Programme Office and reports through the System leaders.
   b) The Quality Improvement programme is monitored through Divisional Clinical Effectiveness committees and Quality Improvement project triage group. A Quality Improvement register details the projects by Division and Harm (if applicable). Contained within the Quality Improvement programme is the Harm

Free Care programme which includes Falls, Deteriorating Patient, Medication errors, Pressure Ulcers, Infection Prevention.

c) The ELHT programme is monitored through the Improvement Practice Office reporting to the Operational Delivery Board, Finance and Performance Committee, Quality Committee and the Executives through the leadership wall and Improvement Guiding Board.

d) Divisional improvement is monitored through the Divisional Governance structures.

7. The external sources of assurance has been updated to include the following:

a) System-wide reporting is currently being developed through the Pennine Lancashire Business Intelligence group and the Together a Healthier Future programme.

b) System-wide Programme Boards are currently being developed which will focus on delivery of system priorities and will dovetail to the Improvement Practice Office. These Boards cover Urgent and Emergency Care, Scheduled Care, Integrated Community Care and Mental Health. A Programme Coordination Group, consisting of senior responsible officers and delivery leads, is also being established and this will replace the existing Partnership Delivery Group.

8. The gaps in control section has been updated to include the risk to external support via NHSI Vital Signs programme due to unavailability of NHSI consultant. A new consultant will commence in post in September, thus the gap will be for a short time.

9. The actions planned/update section has been updated to include the first meeting of the Integrated Community Care Board will be held in September 2019 and will be subsequently held on a monthly basis.

Risk 2: Recruitment and workforce planning fail to deliver the Trust objectives

10. It is proposed that the **risk score remains at 20 (likelihood 5 x consequence 4).**

11. The key controls section has been updated to include the following:

a) Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the ICS Workforce Transformation Board.

b) Divisional Performance Meetings and Operational Delivery Board monitor on-going performance, actions and risks.

c) People Strategy aligned to deliver the Integrated Care Partnership and Trust workforce objectives and is cognisant of the NHS Interim People Plan.

12. The external sources of assurance have been updated to include:

a) ICS wide LWAB (Local Workforce Action Board) - looking at nurse recruitment across the whole system.

13. Gaps in assurance have been updated to include the following:
    a) Awaiting national approach to pension issue.
14. Actions and updates have been updated as to include the following:
    a) Equality and Diversity Action Plan updated and developing Equality and Inclusion Strategy in October.
    b) Annual Festival of Diversity planned for May 2020.
    c) The new Equality and Inclusion Group has been established to consider the wider diversity agenda. Three staff networks have been agreed to be stablished (BME, LGBTQ and Disability).
    d) An ICP workforce strategy has been developed and we are in the process of re-focusing the workforce transformation group. We are working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSI LEAN (Vital Signs) improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Retention Strategy is being developed to underpin a system-wide approach to recruitment.
    e) Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally, due to launch in September 2019.

Risk 3: Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

15. The **risk score remains 12** (likelihood 3 x consequence 4).
16. The potential sources of assurance section has been updated to include the following:
    a) Tripartite meeting of the Trust Board and CCG Governing Bodies held at the end of July 2019.
17. The actions planned section has been updated to include the following:
    a) ICS five year plan is due to be submitted on 27 September, final draft due in at the end of November 2019.

Risk 4: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework

18. The **risk score remains at 20** (likelihood 5 x consequence 4).
19. The potential sources of assurance section has been updated and now includes the following sources of internal assurance:
    a) Reinstatement of the monthly Finance Assurance Board (FAB) chaired by the Chief Executive. Attended by Executive and Finance colleagues to the financial position, forecast and SRCP performance. The gaps in control section has been updated with the following:
    b) Monthly agency meeting *(moved from actions planned)*
20. The gaps in control section has been updated to include:
    a) Controls around transformation schemes and SRCP to be monitored by the FAB and the Finance Department. Divisions will be held to accountable via the FAB.
    b) Failure to meet Provider Sustainability Fund requirements both as a Trust and an ICS.
21. The actions planned has been updated with the following:
    a) Risks in relation to the impact of the changes to CQUIN to the end of 2019/20 are being managed and reported to the Quality Committee.
    b) Divisional recovery plans sent out on the 23 of August to be reported back to the FAB on the 19th of August and an update to be provided to the Finance and Performance Committee due on the 30 of September.

Risk 5: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

22. The **risk score** remains at **16** (likelihood **4** x consequences **4**).
23. Key controls have been updated to include the following:
    a) Weekly operational performance meeting covering RTT holding lists and key operational indicators. Separate dedicated weekly cancer performance meetings. Fortnightly deep dive at the Executive team meetings.
    b) Appointed Clinical Scheduled Care Lead (Associate Medical Director) who will work with Clinical Leads to create and monitor improvement plans for the RTT and holding list positions.
    c) Outpatient Improvement Group established in July. Focused on reducing face to face outpatient appointments to improve the RTT and holding list position.

d) Improvement dashboard and breach analysis report developed and presented to the Executive team, this will continue on a regular basis.

24. Internal sources of assurance have been updated to include:

a) The appointment of an Emergency Department (ED) senior nurse and substantive ED manager to improve productivity, performance and the patient experience.

b) Directors of Operation aligned to each division to provide senior operational support and oversight.

25. External sources of assurance have been updated to include the review commissioned by the Cancer Alliance of internal processes for cancer performance management and patient tracking. The Trust was highly commended for its strong processes in place.

26. The gaps in assurance section has been updated with the challenges to the delivery of the four hour standard, the 62 day cancer standard and RTT.

27. The actions have been updated to include the following:

a) Complaints reviewed weekly by the Executive team.

b) Refocused efforts across clinical teams and system partners to reduce long length of Stay (LoS) patients and Delayed Transfers of Care (DTOC). Monitored at the Executive team meetings.

c) Report to the Quality Committee on the holding list and 18 week RTT action plans to be provided bi-monthly, with the next update to be provided at the meeting in September.

d) RTT and Holding Lists - streamlined directorate level trajectories and action plans are now in place and reviewed at weekly operational meetings. Updates will be provided via the Finance and Performance Committee with the next report due at the meeting in September. A new performance dashboard is also in development for use across the Trust.

e) NHSI have confirmed the dates for this year's PLACE assessments as running from 16 September to the 22 November. Oversight of the reports will be provided by the Quality Committee and summary updates as part of the committee updates to the committee to the Board.

f) Increase in the numbers of pathways that go to ambulatory care directly, such as low risk chest pain patients - this is intended to reduce pressure on A&E and improve the patient experience.

g) Older Peoples Rapid Assessment (OPRA) Unit expansion planned for the end of September that will give additional assessment capacity and support the reduction in the length of stay.

h) Substantive ED senior nurse recruited and starting in September, this is part of the accelerated Ambulatory Care Programme monitored by the NHSI – a visit is planned for the 2 October to enable the Trust to gain assurance that we are utilising our ambulatory pathways to their full potential.

i) Redesign of the Acute Mental Health Pathway by LCFT is expected to be associated with improved crisis intervention services in the community. This is planned to allow the closure of the mental health decision units across Lancashire. Whilst the changes are welcomed in principle, ELHT have emphasised the need to see appropriate community services in place to support the changes, and are working closely with LCFT. Plans are also being developed for an enhanced mental health assessment unit co-located to the Emergency Department, staffed by Mental Health liaison teams.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance, 4 September 2019

Our Strategic Objectives

1. **Put safety at the heart of everything we do**
2. **Invest in and develop our workforce**
3. **Work with key stakeholders to develop effective partnerships**
4. **Encourage innovation and pathway reform and deliver best practice**

Reference Number: BAF/01

Responsible Director(s): Director of Finance and Medical Director

Aligned to Strategic Objectives: 1, 2, 3 and 4.

Strategic Risk: Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care.

Consequences of the Risk Materialising:
1. Ability to deliver against the constitutional standards and organisational delivery would be adversely affected
2. Inability to provide financial assurance to the Board
3. Reduced ability to integrate primary and secondary care
4. Reduced ability to have the right workforce planning
5. Reduced ability to achieve access and operational standards
6. Reduced ability to improve quality standards

Key Controls *What controls/ systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score**			
						2018/19		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
We have developed the 2019 plan for the Trust in conjunction with the Pennine Lancashire ICP partners to achieve a single plan for the ICP. This focusses on delivering our quadruple aim of balancing quality with delivery/performance, finances and impact of change on people (patients, staff or the public). The Trust has invested in an Improvement Practice team who will work with transformation and quality improvement teams across Pennine Lancashire and the Trust to lead, facilitate and deliver improvement in line with the agreed priorities from the planning round. The programme also aligns the improvement methodologies utilised across the Trust and wider-ICP to ensure consistency of approach. The ICP programme is monitored through the Pennine Lancashire Programme Office and reports through the System leaders. The ELHT programme is monitored through the Improvement Practice Officer who report to the Operational Delivery Board, Finance and Performance Committee, Quality Committee and the Executives through the leadership wall and Improvement Guiding Board. The Quality Improvement programme is monitored through Divisional Clinical Effectiveness committees and Quality Improvement project triage group. A QI register details the projects by Division and Harm (if applicable). Contained within the Quality Improvement programme is the Harm Free Care programme which includes Falls, Deteriorating Patient, Medication errors, Pressure Ulcers, Infection Prevention. Divisional improvement is monitored through the Divisional Governance structures.	**Internal Assurances** The Trust planning process has been designed to enable the identification of a single set of transformation priorities for the Trust in conjunction with ICP Partners. The priorities identified are aligned to the Trust's Clinical Strategy, the ICP priorities as outlined in the Pennine Plan, to key ICS priorities and to the NHS Long-Term Plan. The Trust has adopted and is implementing (and building capacity to undertake) improvement (incorporating quality improvement, transformation/service development and improvement) utilising a consistent improvement approach based on Lean. The Trust has invested in dedicated improvement capacity through the development of the Improvement Practice Team/Office and has sought, through the planning round, to align capacity across the organisation to the delivery of a single plan. The Trust has invested in external expert advice and support via the NHS Improvement Vital Signs Programme to ensure improvement is delivered to a high standard. Through alignment of priorities to the Improvement Practice Office there will be oversight of all improvement work. Operational and Executive oversight will be provided via: • Executive Visibility Wall – bi-weekly • Guiding Board (Improvement Board) - monthly Board assurance will be provided via reporting to: • Finance and Performance • Quality Committee • Trust Board (information papers and minutes) A revised clinical divisional structure has been implemented with a newly formed community services and intermediate care division to strengthen our leadership and provide capacity to support the transformation and partnership working with the wider system. The Acting Chief Executive of the Trust appointed as the Professional Lead for the Pennine Lancashire ICP influencing the collaborative work on transformation. Director of Operations responsible for community and intermediate care services is one of the portfolio delivery leads for the Pennine Lancs ICP. **External Assurances** System-wide reporting is currently being developed through the Pennine Lancs Business Intelligence group and the Together a Healthier Future programme. ICP system level aiming to prioritise health improvements that can deliver beneficial outcomes more quickly. Care Professional Board workshop with a wider audience held in August 2018 resulted in the creation of Pennine Lancashire Professional Leadership Committee, bringing together relevant professionals to support the Pennine Lancashire transformation. Several senior ELHT clinicians attending and actively participating in the Professional Leadership Committee and associated workshops. System wide reviews completed including a discharge community and intermediate care diagnostic assessment by Newton Europe and a Lancashire intermediate care review completed by Carnall Farah. The progressions of these reviews and their associated recommendations are being overseen by the Pennine Lancashire intermediate care programme board which reports into the Pennine Lancashire Together a Healthier Future programme. To support a whole system multi agency approach to the development of community services, Integrated Neighbourhood Local Community partnerships (LCP's) have been established for Blackburn with Darwen and East Lancashire and these report into the Pennine Lancs Together Healthier Future programme. There is commitment to the alignment of the improvement approach across the ICP. Work is on-going to align approaches and deliver associated training to upskill across the ICP There has been good participation by system partners in several system-agreed improvement events. There is ongoing alignment of improvement resources across the ICP including commissioning portfolios. System-wide Programme Boards are currently being developed which will focus on delivery of system priorities and will dovetail to the Improvement Practice Office.These Boards cover Urgent and Emergency Care, Scheduled Care, Integrated Community Care and Mental Health. A Programme Coordination Group, consisting of senior responsible officers and delivery leads, is also being established and this will replace the existing Partnership Delivery Group. System-wide reporting is currently being developed through a review of current ICP governance structures. **Internal / External Assurances** A revised clinical divisional structure has been implemented with a newly formed community services and intermediate care division to strengthen our leadership and provide capacity to support the transformation and partnership working with the wider system. In addition a community services transformation board meets monthly and this includes a commissioner representative as part of its membership. A community systems board has also been established which meets monthly, reporting to the community services transformation board.	16	10	20	4x4	20	20	20	16

Gaps in Control *Where we are failing to put controls/ systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/ systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
Capacity and resilience building in relation to improvement is in early phase Short term regulatory targets detracting from the delivery of short to medium term objectives of the transformation programme resulting in competing priorities in delivery of business as usual and improvement work Dependency on stakeholders to deliver key pieces of transformation Financial constraints Transformation priorities not yet fully aligned to appraisal and objective setting Capacity and time to release staff to attend training Linking between clinical effectiveness/quality improvement and the Improvement Office needs to be further developed System wide working is still developing, and priorities are not yet completely aligned Risk to external support via NHSI Vital Signs programme due to unavailability of NHSI consultant - new consultant now starts after September, short term gap.	Assurance in place about the Trust planning process and plans for implementation of the Improvement Approach, but assurance about the delivery and benefits is still work in progress at this stage. Further assurance needed on alignment of plans and planning processes across the ICP There is an ongoing dependency on external stakeholders to deliver key pieces of transformation. Exploring the opportunities in a changing leadership at collaborative level and linking into the new system executive roles. Whilst there is one agreed set of priorities there may still be insufficient capacity to deliver the required level of change/improvement Not delivering the percentage increase regarding the Productivity and Efficiency transformation that we aspire to. Internal changes are needed, external efficiencies require Pennine Lancashire whole system working. Interlinkage between QI and transformation IPO is in the early stages and requires more development.	There will be a re-focus on delivery and impact via the Guiding Board and Executive Visibility Board which will improve assurance to Trust Board sub-committees Improve the robustness of reporting of impact through adoption of A3 Improvement Practice Team now fully established. Staff undertaking practice coach training and have an agreed portfolio of work aligned to agreed priorities. Continued alignment of improvement approach for the Trust – The Pennine Lancashire Way Establishment of system-wide Programme Boards e.g. Scheduled Care Board to ensure alignment of priorities across the ICP Consider options for continuation of external support First meeting of the Integrated Community Care Board to be held in September and will be subsequently held on a monthly basis.

Reference Number: BAF/02

Responsible Director(s): Director of HR and OD

Aligned to Strategic Objectives: 2, 3 and 4.

Strategic Risk: Recruitment and workforce planning fail to deliver the Trust objectives

Consequences of the Risk Materialising:
1. Gaps on rotas impacting adversely on ability to deliver safe, personal and effective care
2. Negative impact on financial position through high use of agency staff
3. Inability to staff escalation areas
4. Inability to create an integrated workforce
5. Unable to recruit a representative workforce
6. Inability to release staff for training and appraisal

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score**			
						2018/19		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
Workforce Transformation strategy in place and associated Divisional and Trust-wide plans monitored through the ICS Workforce Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans. Divisional Performance Meetings and Operational Delivery Board monitor on-going performance, actions and risks. Reports to Finance & Performance Committee Recruitment strategy and plans linked to Workforce Plans. Trust Workforce Controls group in place to review all vacancies and support the Workforce Transformation strategy. One Workforce Planning Methodology across Pennine Lancashire Workforce planning at STP level, e.g. Apprenticeships, recruitment and retention initiatives, collaborative medical banks and talent management. Pennine Lancashire Workforce Transformation Group. People Strategy aligned to deliver National ICB, ICP and Trust workforce objectives and is cognizant of the NHS Interim People Plan.	**Internal Assurances** On-going monitoring of vacancies and bank/agency usage at Trust Operational Delivery Board via Trust performance report. Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. WRES action plan with timelines in place. Regular reporting to the Board on progress. Work with the Fanshawe Report. Ongoing monitoring of workforce diversity through the re-establishment of the Diversity and Inclusion Steering Group and Trust Operational Delivery Board. Workforce Control Group regularly reports to the Executive on workforce control measures and indicators. Dashboard developed. Annual report to the Quality Committee. Joint Medical and Non-Medical Agency Group in place. Dashboard giving overview of bank/agency usage presented to the Executive team meeting monthly. Additional scrutiny from a nursing perspective. The Performance Assurance Framework Lean Programme (Vital Signs) overall linking into workforce transformation. Implementation of Allocate rostering/ publication dates for rosters. Uptake of flu vaccine across the workforce. Completion rates of the annual staff survey and low rates of turnover. Integrated performance report. Implementation of new absence management process to support staff attendance and to mitigate need for use of bank and agency. Workforce Dashboard reporting key performance indicators within division on a monthly basis, Details of these reported on a quarterly basis to the Finance & Performance committee. A Senior Medical Staffing Performance Review Group established - responsibility for reviewing all consultant job plans, consultant vacancies etc. adding further rigor on our appropriate use of resource. Workforce Solutions Board now aligned to deliver Trust Business Plan & Clinical Strategy. **External Assurances** Friends and family test (further detail in BAF risk 5) Benchmarking of agency spend is available through the Model Hospital data. Collaboration across the ICS on agency usage. Joint work taking place across the ICS to consider implications and options to mitigate the impact on pensions. Broader quality and diversity group and a better understanding of workforce demographics in relation to the over 55 workforce. ICS collaboration on Careers, International Recruitment and Workforce mobility. Pensions link to Finance and Performance 'Gaps in Assurance'. ICS wide LWAB (Local Workforce Action Board) - looking at nurse recruitment across the whole system.	16	10	20	5 x 4	12	20	20	20

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions. Reduction of CPD monies from HEE (could be off-set by the apprenticeship levy). Varying incentive schemes/packages across provider sector. Implications of Brexit on the workforce - uncertainty/ workforce are yet to be determined. Integrated workforce assurance group The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity.	Inability to control external factors (Brexit, visas etc). Awaiting national approach to pension issue. Regulators stance on safe staffing and substitution of roles in place of registered workforce. Lack of data/intelligence regarding the number of nurses and clinical staff in the 55+ age category and the related risk of 'brain drain' in the coming years. Work has been done by ICS across the system but it does not contain the level of detail needed for each Trust. Efforts need to be made to understand and refine the workforce data in order to address the issues in the Trust.	Currently there are a further 113 external nurses in the recruitment pipeline due to start with the Trust between now and May 2019. 16 nurses have been sourced and started via the Global Learners Programme with a further 33 in the registration process for the programme. 3rd cohort has been interviewed from recruit to arrival in post there is an approximate lead time of 6 months. HCA recruitment continues, contributing to the reduction in HCA bank shift requests adding further stability and flexibility to our support workforce. E&D Action Plan updated and developing Equality and Inclusion Strategy in October. Annual Festival of Diversity planned for May 2020. Culture and Leadership Programme 12 month delivery plan ongoing. The new Equality and Inclusion Group has been established to consider the wider diversity agenda. Three staff networks have been agreed to be stablished (BME, LGBTQ and DIsability) Shadow Board ongoing, due to conclude in September. Vital Signs improvement programme is underway to improve employee experience from recruitment through to them leaving the organisation. The Hire to Retire VSA has now delivered improvements over 90 days and is now working on improvements for the next 90 days reporting in June. An ICP workforce strategy has been developed and we are in the process of re-focusing the workforce transformation group. We are working with ICP partners to undertake systematic and integrated workforce transformation linked to the NHSI LEAN improvement programme. We are working across the ICS to develop a mobility agreement to assist with the movement of staff across the region. A Recruitment and Retention Strategy is being developed to underpin a system wide approach to recruitment. 2 Workforce Repository and Planning Tool (WRAPT) planning projects are underway across the organisation. HEE funding secured to develop clear clinical leadership for workforce transformation through the WRAPT process. Training commenced in May 2019. Establishment of a Care Academy for Pennine Lancashire to secure a talent pipeline locally, due to launch in September 2019. Scoping of potential opportunities to manage medical agency staffing differently commenced in April 2019. The Trust is working with partners across the ICS to develop a co-ordinated response to the aforementioned pensions issues.

Reference Number: BAF/03

Responsible Director(s): Chief Executive, Director of Finance, Director of Service Development and Medical Director

Aligned to Strategic Objectives: 3 and 4

Strategic Risk: Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities.

Consequences of the Risk Materialising:
1. Failure to engage leadership and wider stakeholder groups
2. Failure to secure key services for Pennine Lancashire.
3. Failure to maximise our potential as a provider of key specialist services (Stroke etc.) across the STP footprint.
4. Delay in the speed of implementing integrated solutions and planning public engagement due to less effective partnerships.
5. Capability and capacity to deliver their component of the partnership working and deliver their own statutory obligations could cause a transfer of risks from partners to the Trust.

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score**			
						2018/19		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
Pennine Lancashire System Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. At Pennine Lancashire level health improvement priorities agreed (HIMPs). HIMPs reporting to the Professional Leadership Committee (PLC) Number of senior clinicians involved with ICS work groups. Professional Leadership Committee (PLC) has ELHT representation. ICS Finance Group and ICP Finance and Investment Group with ELHT senior representation . The ELHT Accountable Officer is the senior responsible officer (SRO) for the Pennine Lancashire Transformation Programme, sits on the System Leaders Forum and on the Integrated Care System for Lancashire and South Cumbria (ICS) Programme Board. The Trust's Acting Chief Executive is the professional lead for the Pennine Lancashire ICP. Vital Signs Programme ensures the ICP as a system is having a significant participation as part of the transformation programme. ICS level Planning Group has been formed and met for the first time on 3 December 2018. The Director of Service Development attends to represent the ICP. The role of the group is centred around the 5 year plan which is due to be developed by Summer 2019.	**Internal Assurances** Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives progress the generation of ideas and options with external stakeholders. Potential gains in strengthened reputation with regulators and across the ICS footprint with regular reporting to the Board via the Finance and Performance Committee on progress, milestones and risks linked to the gateway process. Mitigation in place for creating single teams across the system, e.g, 'one workforce' with timelines for implementation. Progress covered under BAF risk 2. **Internal / External Assurances** The Pennine Lancashire and ICS Cases for Change have been published. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health and Wellbeing Improvement Partnerships (HIMPs) at Pennine Lancashire level reviewed around the health improvement priorities and the majority are relatively well established with minor changes needed to link into the new structures. ICS governance oversight forms part of the Audit Committee standing agenda for 2018/19. Fostering good relationships with GP practices and Federations e.g. service pilots and as a result of tenders and general dialogue. Pennine Lancashire ICP Memorandum of Understanding agreed by stakeholders. ELHT Chief Executive chairing the ICS Providers' Forum. ELHT hosting the Providers Programme Director for the ICS Provider Board who reports to the Chief Executive of ELHT. Director of Service Development leading on the construction of the work programme with the Directors of Strategy from all the providers. Component business cases at Pennine Lancashire level forming a draft overarching ICP plan. Plan on a page for the ICP, connecting to the Plan on a page for ELHT completed and shared with the Commissioners. CEO of ELHT and Accountable Officer of East Lancashire CCG jointly chairing the Pennine Lancashire ICP Programme. Posts for Portfolio Holders at ICP level are in development. Cultural development programme for system level leadership established with involvement of all senior leaders across the ICP. ICS architecture on clinical services is developing (eg pathology, stroke and frailty). Positive feedback from service reviews (stroke and endoscopy). Structures in place for the Out of Hospital stream with the Trust significantly contributing to the workstream. Clinical leadership through the Professional Leadership Committee (PLC) at Pennine Lancashire ICP level giving consistent message about the importance of working as a system. Strengthening the relationship with primary care networks' leadership. Associate Medical Director for Service Improvement appointed, increasing our capacity for clinical leadership in relation to service improvements. Pennine Lancashire Delivery Group has ELHT representation and is chaired by the Trust's Chief Executive. A&E Delivery Board meets monthly, chaired by the ELHT Chief Executive. Progress on collaborative efforts in relation to the emergency pathway is covered under BAF risk 5. Vital Signs is a system wide transformation programme across the Pennine Lancashire ICP. Patient experience strategy envisages good patient and public involvement to support the collaborative transformation. Progress with work covered under BAF risk 1. Producing ELHT demand and capacity plan to be signed off by the Executive Team. The wider system demand and capacity plan will be signed off by the Partnership Delivery Group. Pennine Lancashire Partnership Delivery Group is the engine/delivery room for the ICP. The group has been given delegated authority from the Pennine Lancashire Leaders' Forum and the planning process is driven through this group. The Pennine Lancashire system planning reports into the Partnership Delivery Group. Joint accountable officer for CCG's is now in post. A system financial and investment group for the ICP looking into the priorities and aligning them with the financial envelope for the local system. Creation of single teams to deliver the transformation agenda at ICP system level. Priorities of the individual organisations and those of the system aligned/agreed. Tripartite meeting held at the end of July.	16	12	12	3x4	12	12	12	12

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
System leaders agreed a process to develop the governance system across Pennine Lancashire; however this is still in development ICS System Management model is in early stages of development. Decision making process for Pennine Lancashire system will need agreement. There is a need for consistent leadership across the system. in order to ensure that we continue prioritising in line with system affordability. Building trust and confidence and agreeing collaborative approaches to service provision	Timeline for consultation with public - uncertainty about the detail of the consultation for the component business case at ICP level. Lack of unified approach in relation to procurement by Commissioners. Priorities of CCGs starting to be aligned with priorities for pathway redesign (e.g. stroke) but this work is still in the early phases. Future role of NHSE/NHSI merged teams to be determined. Ensuring consistent capacity to work externally as well as internally by building system collaboration into the leadership roles and having good joined leadership programmes. Adequate assurance mechanism that the service integration plans are on track together with the rigour of governance arrangements/lack of delegation from the sovereign bodies to the system. It is unclear what the impact of the changes in senior leadership in partner organisations will be. Understanding what is happening to providers with regard to financial milestones in the ICS.	Regular updates provided to Board and the Audit Committee. Standing agenda item at Execs and Trust Board. Across the ICS footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology. At ICS level all providers met to formulate work programme - 3 categories of services agreed a) services that are fragile now b) services where there is no immediate risk but possible in the not too distant future c) services that need to be managed across the whole footprint. Agreement on the way of taking this forward to be agreed. Prioritisation of diagnostics, pathology and cancer work streams agreed. Developed work programme discussed by the Provider Board at ICS level. and work on developing future configuration continues, no timelines for completion set at this stage. Meetings are ongoing regarding the acute Programme and more focused work is taking place in Stroke, Vascular, Urological Cancer and Diagnostics. A range of services are being developed for Head & Neck. Pennine Lancashire ICP component business case. Focus on LDP level wider deliverables. East Lancashire CCG extended the Community Services contract by 12 months allowing for the principles of the new clinical model at ICP level to be developed. Ongoing progress is being made with more focus on the future model of care (not the current model of care). An update was provided at the Trust Board in March 2019. Neighbourhood system event held at end of January 2019. Subsequent 'big ticket' events were held and Value Stream Analysis (VSA) planned under the Vital Signs Programme. Good co-production on developing clinical model across the ICS for CAMHS services was presented to the Commissioners. Clinical model accepted,. A neighbourhood system event held at end of January 2019. supporting, ongoing discussions about affordability with help from the Northumberland, Tyne and Wear Trust.The model (stage 1) had been signed and providers are working on the detail (stage 2). A timetable has been produced, presented to local commissioners and approved by them (1 year plan). Milestones have been developed and a financial exercise has been undertaken to determine the resources required to implement the new model. The Director of Service Development has led discussions with other providers of CAMHS services about potential future configurations and alliance, the model was universally supported. Agreement reached to focus on all aspects of improving the emergency pathway - ED, Assessment Same Day Emergency Care, Discharge and out of hospital services and the acute adult mental health pathway. The Trust is aiming to develop a clear and succinct integrated action plan with associated metrics over the next six weeks. ICS five year plan due to be submitted on 27th of September, final draft due in at the end of November, well represented at ELHT and ICP level. Well placed to work well with the ICP

Reference Number: BAF/04

Responsible Director(s): Director of Finance

Aligned to Strategic Objectives: 3 and 4.

Strategic Risk: The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework

Consequences of the Risk Materialising:
1. Inability to invest and maintain the estate
2. Potential negative impact on safety and quality/increased risk of harm
3. Financial Special Measures
4. Inability to pay suppliers/supply disruption
5. Increased cost of borrowing

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score**			
						2018/19		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
Budgetary controls (income & expenditure) in place including virement authorisation, workforce control, monthly performance meetings and variance analysis. Measures to mitigate financial risk overseen by Finance and Performance Committee.	**Internal Assurances** Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Using the Performance Accountability Framework (PAF) to provide assurance that action is taken to help ensure the delivery of objectives. Financial objective included in individual appraisals. Setting of financial objectives in senior management appraisals. Budget setting Financial Forecasts Briefings on risk Pipeline of schemes to reduce cost. Use of data sources (e.g. Model hospital data.) to drive improvement and mitigate deterioration. Evidencing the routine use of benchmarking data to drive positive change. Revised Performance Accountability Framework presented to the Finance and Performance Committee on 29 October 2018 and to the Operational Delivery Board on the 31 October 2018, with final approval by the Finance and Performance Committee at the end of November. Reinstatement of the monthly Finance Assurance Board (FAB) chaired by the Chief Executive. Attended by Executive and Finance colleagues to the financial position, forecast and SRCP performance. Monthly agency meeting (MOVED FROM ACTIONS PLANNED) **External Assurances** External audit view on value for money. Model Hospital benchmarking (including cost per Weighted Activity Unit). ICS Led Theatre Productivity analysis. GIRFT Programme	16	12	20	5x4	20	20	20	20

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
Additional workforce controls to remain in place. Policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the FAB and the Finance Department with Division to be held to account via the FAB. Gaps in control regarding funding for A&E and PSF funding - recovery plan underway. Lack of standardisation in applying rostering controls. Weaknesses in discretionary non-pay spend. Deterioration in the underlying financial position requiring additional transformation schemes in 2018/19. SRCP being delivered non-recurrently. Officers operating outside the scheme of delegation. Inadequate funding assumptions applied by external bodies (pay awards). Hidden costs of additional regulatory requirements - highlighted with NHSI. Cost shunting of public sector partners increasingly managed through ICS and ICP. Failure to meet Provider Sustainability Fund requirements both as a Trust and an ICS. Agency and locum sign off with escalation of cost. Significant external pressures which may intensify internal financial pressure.	Utilise the internal audit programme to test for assurance on core controls, SRCP and transformation plans. Lack of consistency in divisional governance processes. Understanding the changes in income services (NHS and private). Weaknesses in appraisals and accountability framework. Improve oversight of agency spend, capacity list spend and variations to national contracts. Understanding financial milestones and financial delivery of partner organisations - ICS.	Regular updates to Board and Finance and Performance Committee. Actions and risk relating to the achievement of 'incentivised funding' (e.g. Provider Sustainability Funding) will be routinely reviewed. Risks in relation to the impact of the changes to CQUIN to the end of 2019/20 are being managed and reported to the Quality Committee. Agency and locum sign off with escalation of cost, total hours booked and average per hour will be reported to the Finance and Performance Committee from September 2018 as part of the Financial Performance Report. Cash borrowings have increased above plan as a consequence of not delivering A&E PSF and non cash backed SRCP. Detailed plan for 2019-20 to be developed in light of additional financial focus. Divisional recovery plans sent out on the 23rd of August to be reported back to the FAB on the 19th of August and an update to be provided to the Finance and Performance Committee due on the 30th of September. Shared Cost Improvement Programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) group established with the CCGs. Quality Improvement (QI) established Resources Committee to improve the business case process with CCG's - planned for Q1.

Reference Number: BAF/05

Responsible Director(s): Director of Operations, Director of Nursing and Medical Director

Aligned to Strategic Objectives: 1, 3 and 4.

Strategic Risk: The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS Constitution and relevant legislation.

Consequences of the Risk Materialising:
1. Poor patient experience.
2. Increased regulatory intervention, including the risk of being placed in special measures.
3. Risk to income if four hour standard is not met.
4. Risks to safety.
5. Risk of not being able to deliver seven day services.

Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	**Potential Sources of Assurance** *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	**Initial Risk Score**	**Risk Tolerance Score**	**Current Risk Score**	**Likelihood x Consequence**	**Annual Risk Score**			
						2018/19		**2019/20**	
						Q3	**Q4**	**Q1**	**Q2**
Weekly operational performance meeting covering RTT, holding lists and key operational indicators. Separate dedicated weekly cancer performance meetings. Fortnightly deep dive at the Executive team meetings. Engagement meetings with CQC in place monitoring performance against the CQC standards. Quality and safety compliance assessed by each division and assurance through the Divisional Quality and Safety Boards (DQSB) reporting into the Quality Committee Sub-Committees. Divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework reporting through to the Quality Committee and involvement of NEDs on the SPEC Panels and Board approval for the award of SPEC awards. A&E Delivery Board with Emergency Care Pathway assurance feeding into it. System-wide Scheduled Care Board with elective pathway assurance feeding into it. Daily nurse staffing review using safe care/allocate Nursing and Midwifery. Weekly Medical Staffing Review - Nursing and Midwifery staffing review feeding into the annual professional judgement review for all wards. Weekly operational flow meetings at 08.30, 12.30, 15.30, 18.00 and 19.30 = Weekly ED / urgent care performance and improvement meeting. Appointed Clinical Scheduled Care Lead (Associate Medical Director) who will work with Clinical Leads to create and monitor improvement plans for the RTT and holding list positions. Outpatient Improvement Group established in July. Focused on reducing face to face outpatient appointments to improve the RTT and holding list position. Fortnightly phone calls with the NHSI. Improvement dashboard and breach analysis report developed and presented to the Executive team, this will continue on a regular basis.	**Internal Assurances** IPR reporting to the ODB and at Board/Committee level. Regular deep dive into the IPR through Finance and Performance Committee including RTT, all cancer standards and the emergency care standards. ED performance and four hour improvement action plan aligned with the NHSI Rapid Improvement Collaborative and agreed by NHS England. Performance monitoring provided through the weekly operational meeting, Scheduled Care Board (joint Board with CCG) Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments continues. There are currently 13 Silver Accreditation of a ward approved by the Trust Board with further two awaiting approval. Increased number of assessments under the framework planned all inpatient wards completed in ICG and SAS. Work started on Family Care and Community Services and a plan is in place for 2019/20. Significant reduction in the number of complaints upheld by the Ombudsman. Comprehensive system for addressing complaints. Reduction on overall number of complaints, 50+ and 40+ days continues with regular reporting at operational and Board level. Quality Committee will oversee the CQC action plan. Mini mock-CQC visits regularly carried out and focussing on all areas with regular reporting back to the Quality Committee. Reduction in use of nursing agency staff continues. Staffing escalation process for nursing including forecast gaps in staffing and senior decision making. Standard Operating Procedure (SOP) developed and monitoring through Nursing and Midwifery Leaders' Forum. Quality Walkrounds in all clinical areas. The Performance Assurance Framework. Recovery plans in relation to the risks around some of the national trajectories addressed through the Emergency Care Pathway Transformation programme, Scheduled Care Programme, Cancer Improvement Action Plan and Outpatients Improvement Group. Regular monitoring by Executive Team and ODB. Weekly monitoring of complaints and reporting to the Patient Experience Committee and End of Life Care Group, focusing on reducing any 50+ day complaints (non currently in the system). Staffing (nursing/midwifery) report to Quality Committee. NAPF - operational monitoring through the Nursing and Midwifery Leaders' Forum monthly, receiving assurance from the Assistant Director of Nursing and NAPF team and monitoring by matrons at ward level where they carry out mini-NAPFs on a weekly basis to keep up the improvement work and report to Quality Committee (every other meeting). Escalation area in the Victoria Wing at BGTH is now in place. ED senior nurse and substantive ED manager appointed to improve productivity and performance and patient experience. Directors of Operation aligned to each division to provide senior operational support and oversight. **External Assurances** Trust rated 'Good' by CQC in 2018 with improvements in various areas and some outstanding services. Nurse staffing review as part of the IPR. Staff Care Allocate and daily monitoring of allocation for staff and three times daily matrons meetings to monitor. Audit carried out by MIAA for nurse staffing received significant assurance. MIAA have carried out an emergency care risk assessment audit which gained an assurance rating of 'Significant Assurance'. Cancer Alliance commissioned a review of internal processes for cancer performance management and patient tracking. Highly commended with strong processes in place. **Internal / External Assurances** System wide approach to Emergency Care Pathway, as part of monthly A&E Delivery Board supported operationally by the A&E Delivery Group. PLACE assessments - percentage improved in all areas and monitoring continues. Annual PLACE report presented to the Quality Committee for assurance. Nursing and Midwifery Leaders' Forum also monitor. Patient Experience Committee receive minutes of the PLACE Steering Group. NAPF Team also monitors environmental issues linking to PLACE Assessments. Positive responses to Friends and Family Test and patient surveys with improvement areas identified. Monitoring at ward level, local divisions prepare monthly patient experience action plans that feed into the Patient Experience Committee that reports to the Quality Committee. Monthly monitoring is provided by the Nursing and Midwifery Leaders' Forum. Positive response and results from the 2018 National Staff Survey. Inpatient survey 2018/19 results were presented to the Executive team by Quality Health.	15	12	16	4x4	16	12	16	16

Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	**Gaps in Assurance** *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	**Actions Planned / Update** *Dates, notes on slippage or controls/assurance failing.*
Restrictions in the supply of medical, nursing, midwifery and other staff groups to meet demand. Reference in BAF risk 2. Risk of mental health providers not being able to ensure sufficient assessment and treatment capacity. Restrictions in the primary care system to ensure sufficient capacity. Insufficient capacity to deliver comprehensive seven day services across all areas. Insufficient bed capacity to ensure there are no delays from decision to point of admission. The impact of the changes to the pension rules and taxation has resulted in a significant reduction in capacity and additional work being undertaken by senior medical staff. This has resulted in a reduction in clinical capacity which is affecting the Trust's ability to deliver against 18 week RTT and cancer targets.	Staffing gaps on rotas. Gaps in assurance from the medical staffing perspective. E-Rostering inability to fill all vacant shifts/short term sickness or non-attendance. Challenges to the delivery of the four hour standard, the 62 day cancer standard and RTT. Extended waiting times for mental health patients. Continued non-elective activity is placing pressure on the elective care and the RTT standard. Wards and departments overdue for refurbishment due to the lack of decant facilities. Temporary funding secured for an additional member of staff enabling the Nursing Assessment Performance Framework (NAPF) team to carry out further assessments. Increase in Delayed Transfers of Care and increasing number of longer stay patients. Demand and capacity issues relating to senior medical vacancies are affecting the 18 weeks RTT and holding list position.	Complaints reviewed weekly by the Executive team. The Patient Participation Panel held an open day on 17 January 2019. The panel was launched on 27th February 2019 and it is made up of 15-20 people. Two meetings held and panel members receiving training. The Trust is developing a full clinical model regarding the emergency care pathway and ithis s anticipated to be ready for presentation and sign off in 2019. External support sourced for patient flow modelling. Plans for staffing and estates challenges have progressed as follows: 1. Emergency care pathway action plan in place and is monitored monthly through the ECP Programme Board. 2. Ambulatory Care Emergency Unit opened as planned on 14 September 2018. Fortnightly service reviews carried out to ensure service delivery as expected. 3. Business case approved by the Trust Board and submitted to NHSI in July 2018 for the extended acute medical facility. 4. Frailty Assessment Unit opened on 7th January 2019. Surgical & Ambulatory Emergency Care unit moved to the old ambulatory care on 7th of Jan 2019 and additional beds opened on B14. Board receives regular SRCP and transformation updates. Further rollout of E-rostering system. Nursing Assessment and Performance Framework (NAPF) assessments are continuing. 13 Silver Accreditation of wards approved by the Trust Board. with a further two to be presented to the Trust Board for approval. Further inspections planned for a number of wards awaiting third assessment following two green assessments. Work is planned within the NAPF team to develop the process to incorporate non-nursing areas, such as pharmacy and IHSS. Objective is for a 50% reduction in all red wards was achieved by the end of March 2020. Objectives for 19/20 being set as part of the objective setting process. Core 24 (Lancashire Care Foundation Trust mental health programme) implementation commenced in April 2018 and ran until March 2019. Development of mental health decision unit planned by July 2018 had been delayed by external partners. Unit has opened in August 2018. The Trust continues to work with external partners. The system wide action plan for mental health services has been agreed by the ICS in November. Trust's lifecycle upgrade programme (Estates and Facilities) was developed and signed off by the end of April 2019. Programme now commenced. CQC report published on 12 February 2019, improvements in some areas and outstanding services. Action plan monitored by the CQC and through the Quality Committee. Returned action plan in relation to notices regarding fridges, document storage and fluid thickening. Refocused efforts across clinical teams and system partners to reduce long length of Stay (LoS) patients and Delayed Transfers of Care (DTOC). Monitored at the Executive team meetings. Report to the Quality Committee on the holding list and 18 week RTT action plans to be provided bi-monthly, with the next update to be provided at the meeting in September. Clinical model review and development of Medicine and Emergency Care division - improvement for future for Phase 6 - 13 June was carried out. RTT and Holding Lists - streamlined directorate level trajectories and action plans are now in place and reviewed at weekly operational meetings. Updates will be provided via the Finance & Performance committee with the next report due at the meeting in September. A new performance dashboard is also in development for use across the Trust. NHSI have confirmed the dates for this year's PLACE assessments as running from 16th of September to the 22nd of November. Oversight of the reports will be provided by the Quality Committee and summary updates as part of the committee updates to the committee to the Board. Lisa Grendall to provide training for key members. Increase in the numbers of pathways that go to ambulatory care directly, such as low risk chest pain patients - this is intended to reduce pressure on A&E and improve the patient experience. OPRA expansion planned for the end of September that will give additional assessment capacity and support the reduction in the length of stay. Substantive ED senior nurse recruited and starting in September, this is part of the accelerated Ambulatory Care Programme monitored by the NHSI - a visit is planned for the 02nd of October to enable the Trust to gain assurance that we are utilising our ambulatory pathways to their full potential. Redesign of the Acute Mental Health Pathway by LCFT is expected to be associated with improved crisis intervention services in the community. This is planned to allow the closure of the mental health decision units across Lancashire. Whilst the changes are welcomed in principle, ELHT have emphasised the need to see appropriate community services in place to support the changes, and are working closely with LCFT. Plans are also being developed for an enhanced mental health assessment unit co-located to the Emergency Department, staffed by Mental Health liaison teams.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 119

11 September 2019

Purpose Information Assurance

Title	Serious Incidents Requiring Investigation Report (June and July 2019)
Author	Mrs J Hardacre, Assistant Director Safety
Executive sponsor	Dr I Stanley, Acting Executive Medical Director

Summary: This report provides a summary of the Serious incidents Requiring Investigation report, a breakdown of Serious Incidents reported in June and July 2019 and an overview of the CCGs Quality Dashboard.

Recommendation: Members are asked to receive the report, note the contents and are asked to approve the recommendations.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil

regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by: Quality Committee (4 September 2019)

Contents **Page No**

Executive Summary

1. In June and July 2019 the Trust reported 32 serious incidents:
   a) 23 to the Strategic Executive Information System (StEIS)
   b) 9 to Divisional Serious Incident Review Group (DSIRG).
2. In the first 4 months of 2019/20 the trust has reported 42 StEIS incidents, an increase on the first 4 months of 2018/19 (33) of 8 (27%).
3. The top 3 incident categories are:
   a) Pressure Ulcers (33)
   b) Slips, Trips and Falls (18)
   c) Diagnosis Failure / Problem (17) & Treatment problem / Issue (17)
4. These are the same categories as the previous two SIRI reports with the exception of Treatment problem / issue. Both Falls Steering Group and Pressure Ulcers Steering Group have been notified and are working on improvements projects. A thematic review has been completed on incidents under the category of Diagnosis Failure / Problem and the results are included within this report. The report has identified that there are small clusters of incidents of a certain type occurring in certain areas and supports soft intelligence that was already available. Action plans are already in place because of that intelligence.
5. The trust has reported 1 serious incident is June 2018/19 that met the criteria of the NHS Never Event Framework under Retained foreign object post procedure (guidewire still in situ reported as No Harm-Impact not prevented). Completed RCA is due at the Trusts SIRI Panel in August 2019.
6. There have been no breaches of duty of candour for the months June and July 2019.
7. The Clinical Commissioner Group (CCG) dashboard provides assurance on improvements of investigations. There are currently 45 incidents open on StEIS:
   a) 11 for 2018/2019 (reduced from 24 since last SIRI report) and 34 outstanding for 2019/20
      i. There is one incident investigation (Maternity) which is 96 days overdue – the Trust is waiting on the completion of the HSIB investigation and report.

Part 1a: Overview of serious incidents reported through Strategic Executive Information System (StEIS) from April 2017 to July 2019

8. There has been an increase in the number of Serious Incidents (SIs) reported to the CCG when comparing the figures year on year:
   a) 90 SIs reported StEIS incidents 2017/18
   b) 111 SIs reported StEIS incidents 2018/19
   c) 42 SIs reported StEIS incidents in the first 4 months of 2019/20, an increase on the first 4 months of 2018/19 (33) of 8 (27%).

9. A high number of these incidents are de-escalated by the CCG on completion of the investigation as they are deemed unavoidable. Table 1 which shows the reported ELHT figures compared to the final CCG figures for 2017/18 and 2018/19.

Table 1: No of Serious Incidents De-escalated by CCG

Year	ELHT	Incidents De-escalated	% of Incidents De-escalated
2017/18	90	26	29%
2018/19	111	45	41%

10. It was reported in the April 2019 SIRI paper that a peak had been seen in the number of incidents being reported to the CCG in March 2019. This has been monitored for the last four months and no further peaks have been identified.

11. The top four categories for incidents reported over the last 12 months account for (85) 70% of all incidents reported:
   a) Pressure Ulcers (new and old codes) x 33 (27%)
   b) Slip, Trip and Falls x 18 (15%)
   c) Diagnosis failure / problem x 17 (14%)
   d) Treatment problem / issue x 17 (14%)

12. Pressure Ulcer Steering Group and the Falls Steering Group are working with the Quality Improvement Team on Harm Reduction programmes in line with National recommendations.

Thematic review of Diagnosis Failure/Problems

Findings

13. Clusters around errors of judgement in high volume areas such as radiology and ED were identified. It is recognised that there is always the potential for an error of judgement to occur and the trust has robust processes in place to enable learning from these incidents. The fact that diagnostic problems are now visible in our alerting system suggests that our culture is changing to one where errors are not hidden away but reported so that everyone can learn from them and prevent them from happening again.

Actions and learning

14. The highest volume areas are radiology and ED. Both of these areas have addressed the need for continuing education in a way that particularly suits their needs – discrepancy meetings in radiology and educational support on a daily basis in ED.

15. The review has provided assurance that action is being taken to mitigate the risk of diagnostic failure in the areas where it is most likely to occur. The recommendation is that the thematic review is repeated in order to determine whether the number and type of diagnostic failures reduces in response to the interventions taken.

Part 1b: Breakdown of serious incidents reported through Strategic Executive Information System (StEIS) reported in June and July 2019

16. There have been 23 serious incidents requiring investigation (see appendix a) which have been reported through Strategic Executive Information System (StEIS). This is an increase of 44% on the same time period last year when 16 incidents were reported. The main reasons for the increase in the number of incidents reported are:
    a) increase in reporting of pressure ulcers (3 community/4 ward based) – only 2 reported in the same time period last year

17. The trust reported 1 serious incident in June 2018/19 that met the criteria of the NHS Never Event Framework under Retained foreign object post procedure (guidewire still in situ reported as No Harm-Impact not prevented).
    a) Rapid Review completed and states patient remains well
    b) Duty of candour completed (final report will be shared with family)
    c) Investigator nominated and terms of reference completed

d) Round table completed with staff involved

e) RCA report due at August SIRI Panel for discussion and Trust approval.

18. The Trust performance against key performance indicators required against the National Serious Incident Framework.

a) No incidents had breached the duty of candour at the time of writing report (see Table 2)

b) All serious incidents were reported within the required 2 working days of the trust being aware of the incident and confirming level of harm.

Table 2: Incidents Requiring Completion of Duty of candour (as of 2nd August 2019)

	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June 19	July 19
Reported in month	**11**	**11**	**17**	**12**	**15**	**11**	**19**
Completed in 10 days	**11**	**9**	**13**	**11**	**13**	**11**	**11**
Breached	**0**	**1**	**2**	**1**	**2**	**0**	**0**
Structured Judgement reviews meeting the DoC threshold	**0**	**1**	**2**	**0**	**1**	**1**	**1**

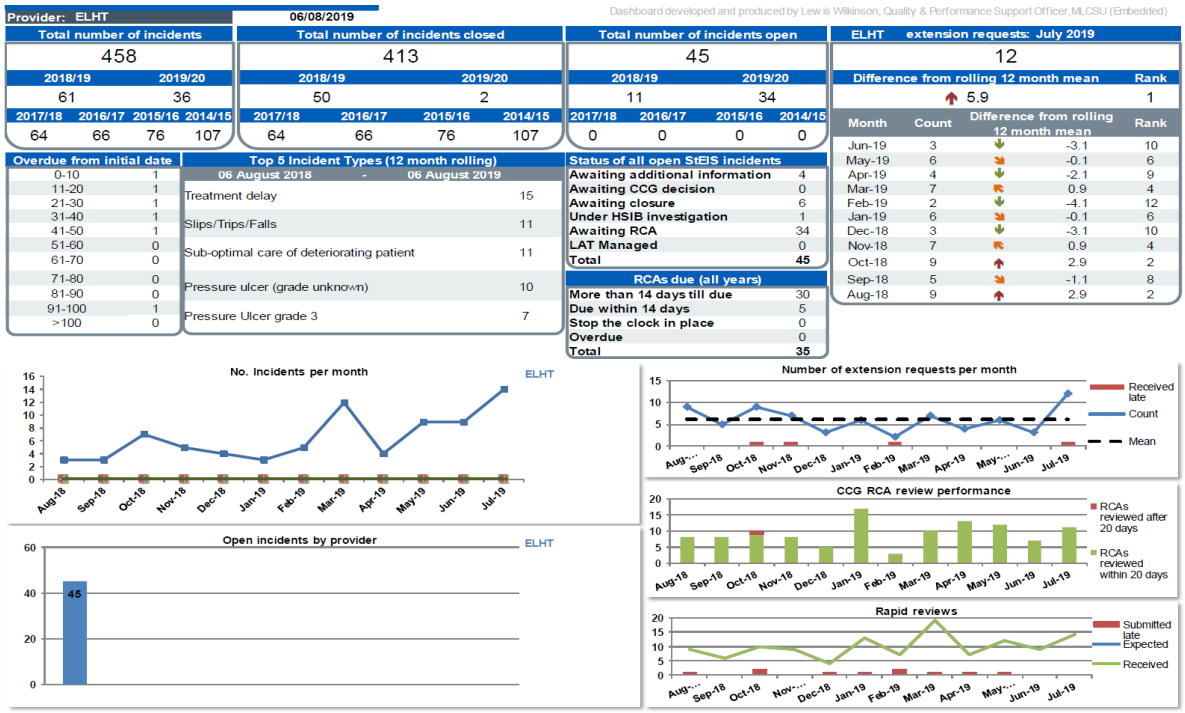
Part 2a: Overview of Divisional Serious Incident review group (DSIRG) from August 2018 to July 2019

19. There has been a decrease in the number of Serious Incidents (SIs) requiring investigation by Divisions when comparing the figures year on year:
    a) 88 reported RCA incidents 2017/18
    b) 69 reported RCA incidents 2018/19
    c) 22 reported RCA incidents in the first 4 months of 2019/20, a decrease on the first 4 months of 2018/19 (23) of 1 (%).
20. There have been no peaks reported in the last 12 months of number of incidents requiring DSIRG investigation.
21. The top three categories for incidents requiring investigation by division over the last 12 months account for 43% of all incidents reported:
    a) Diagnosis failure/problem (11) 16%
    b) Pressure Ulcers (new and old coding) (11) 16%
    c) Treatment problem / issue (7) 10%
22. These are similar categories as the StEIS reported incidents.

Part 2b: Breakdown of Incidents reported to Divisional serious incident reporting groups (DSIRG) in June and July 2019

23. There were 9 incidents (see appendix b) that did not meet the reporting requirements for strategic executive information system incidents (StEIS) but deemed to be serious enough to require a Trust Level RCA investigation.
    a) There has been a 10% decrease on the same time period last year when 10 incidents were reported.
24. Investigations have been completed and presented to DSIRG with lessons learned and action taken which is shared within the areas the incidents have occurred. Action plan monitoring of these incidents are being undertaken to ensure these are embedded with evidence provided and uploaded to our internal incident management system, Datix.

Part 3: Overview of the CCG StEIS Dashboard



25. There are currently 45 incidents open on StEIS:
    a) 11 for 2018/2019 (reduced from 24 since last SIRI report) and 34 for 2019/20
        i. There is one incident investigation (Maternity) which is 96 days overdue – the Trust is waiting on the completion of the HSIB investigation and report.
    b) There have been 12 extension requests in July
    c) There have been no late submissions of rapid reviews for June and July
26. The CCG has identified treatment delay/issues and Pressure Ulcers as the two highest reported categories by the Trust on StEIS in the last twelve months.

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
1	1168045	SAS	28/06/19	N	Error in collecting/processing specimen	Y	Y	De-brief learning scenario undertaken and action matrix devised Review of specimen management policy	Moderate	RCA to SIRI
2	1168052	DCS	28/06/19	Y	Structure Judgement review	Y	Y	No immediate changes initially identified – incident raised through Trusts structured judgement review process	Death / Catastrophic	RCA to SIRI
3	1169421	ICG	22/07/19	Y	Pressure Ulcers	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI
4	1167895	SAS	26/06/19	N	Wrong/delayed diagnosis of condition	Y	Y	No immediate changes initially identified	Moderate	RCA to SIRI
5	1169154	ICG	17/07/19	Y	Pressure Ulcer	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
6	1168764	ICG	11/07/19	N	Pressure Ulcers	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI
7	1166056	FC	28/05/19	N	Possible infection control incident	Y	Y	No immediate changes initially identified	Moderate	RCA to SIRI
8	1168998	ICG	15/07/19	N	Mental Health bed breach from decision to admit	N	Y	No immediate changes initially identified	No harm - Impact not prevented	RCA to SIRI
9	1168630	SAS	09/07/19	Y	Incident raised to review care from Trusts structured judgement review process	N	N		Moderate	RCA to SIRI
10	1166570	ICG	05/06/19	Y	Pressure Ulcer	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
11	1167131	SAS	13/06/19	Y	Incident raised to review care from Trusts structured judgement review process	N	N	No immediate changes initially identified – incident raised through Trusts structured judgement review process	Death / Catastrophic	RCA to SIRI
12	1164832	ICG	07/05/19	N	Treatment delay	Y	Y	No immediate changes initially identified	Moderate	RCA to SIRI
13	1166462	ICG	04/06/19	Y	Slips, trips and falls – fracture	Y	Y	To be monitored through Fall Steering Group	Moderate	RCA to SIRI
14	1168458	ICG	06/07/19	N	Pressure ulcer	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI
15	1167179	ICG	14/06/19	Y	Incident raised to review care from Trusts structured judgement review process	N	N	No immediate changes initially identified – incident raised through Trusts structured judgement review process	No harm - Impact not prevented	RCA to SIRI

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
16	1165569	ICG	20/05/19	N	Safeguarding – Adult – alleged abuse	N	Y	No immediate changes initially identified	Low / Minor	RCA to SIRI
17	1167849	ICG	25/06/19	N	Disruptive/Aggressive/violent behaviour – physical assault (patient on patient)	Y	Y	No immediate changes initially identified	Moderate	RCA to SIRI
18	1166450	FC	03/06/19	N	Never event – Guidewire	Y	Y	Round table meeting held and changes made to ensure packaging of guidewires is clearly labelled.	No harm - Impact not prevented	RCA to SIRI
19	1164570	SAS	02/05/19	N	Omission of medication	Y	Y	To be monitored through Medicines Management Group	Moderate	RCA to SIRI
20	1166874	ICG	10/06/19	Y	Slips, trips and falls – fracture	Y	Y	To be monitored through Falls Steering Group	Severe / Major	RCA to SIRI

Number	eIR	Division	Incident reported	Reported to STEIS within 2 working days	Category/Allegation	Relevant to Duty of candour	Rapid Review	Any immediate changes initiated	Level of harm	Next steps
21	1169650	SAS	25/07/19	N	Pressure Ulcer	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI
22	1169249	ICG	19/07/19	N	Delay in treatment	Y	Y	No immediate changes initially identified	Moderate	RCA to SIRI
23	1169874	ICG	29/07/19	Y	Pressure Ulcer	Y	Y	To be monitored through the Pressure Ulcer Steering Group	Moderate	RCA to SIRI

	eIR1	Division	Incident reported	Category/Allegation	Relevant to Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
1	1169149	ICG	17/07/19	Delay in x-ray results being acted upon	Y	Y	No immediate changes initially identified	Moderate	RCA to DSIRG
2	1167077	SAS	13/06/19	Return to theatre	Y	N	No immediate changes initially identified	Moderate	RCA to DSIRG
3	1167119	FC	13/06/19	Notification received of maternal death	N	N	All maternal deaths are to be investigated within 12 months post-delivery in line with national guidelines	No harm - Impact not prevented	RCA to DSIRG
4	1168851	ICG	12/07/19	Complaint/SJR	N	N	No immediate changes initially identified	No harm - Impact not prevented	RCA to DSIRG
5	1169033	SAS	16/07/19	Pressure ulcer – cat 2	N	N	To be monitored through the Pressure Ulcer Steering Group	Low / Minor	RCA to DSIRG
6	1167759	SAS	24/06/19	Pressure ulcer – cat 2	N	N	To be monitored through the Pressure Ulcer Steering Group	Low / Minor	RCA to DSIRG

	eIR1	Division	Incident reported	Category/Allegation	Relevant to Duty of candour	Rapid Review done?	Any immediate changes initiated	Level of Harm	Next steps
7	1168535	ICG	07/07/2019	Pressure ulcer – cat 2	N	N	To be monitored through the Pressure Ulcer Steering Group	Low / Minor	RCA to DSIRG
8	1169427	SAS	22/07/2019	Medication error	Y	Y	To be monitored through Medicines Management Group	Moderate	RCA to DSIRG
9	1168255	SAS	03/07/2019`	Pressure ulcer – cat 2	N	N	To be monitored through the Pressure Ulcer Steering Group	Low / Minor	RCA to DSIRG

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 120

11 September 2019

Purpose Information
Action
Monitoring

Title	Integrated Performance Report
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mrs S Gilligan, Director of Operations

Summary: This paper presents the corporate performance data at July 2019

Recommendation: Members are requested to note the attached report for assurance

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

(120) Integrated Performance Report

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

Board of Directors, Update

Corporate Report

Executive Overview Summary

Positive News

- There were no never events in July.
- Cancer 31 day subsequent treatment (surgery) was achieved in June.
- There were no breaches of the 52wk standard at the end of July.
- The number of ambulance handovers over 30 minutes continues to show improvement.
- HAS compliance is showing significant improvement.
- For 2019-20, the Trust has agreed an underlying control total of a £7.0 million deficit. At month 4, the Trust is reporting a £3.8 million underlying deficit, in line with its financial plans.
- The 6wk diagnostic target was met at 0.7% in July
- Trust turnover rate is showing significant reduction
- ELHT were in the top half of best performing Trusts in 2018-19 for rate of clostridium difficile (HOHA & COHA) infections.

Areas of Challenge

- One post 2 day MRSA infection was detected in July.
- There were nine clostridium difficile infections detected during June ('Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)', which is above trajectory for the month. The cumulative position is 24 against trust target of 51 for the year.
- E-coli post 2 day bacteraemia was above trajectory in July.
- Nursing and midwifery staffing in July 2019 continued to be a challenge, with 2 areas falling below an 80% average fill rate for registered nurses on day shifts.
- The 'Emergency Care 4 hour standard' (Pennine A&E Delivery Board) is showing deterioration and is consistently below standard at 81.5%
- A&E Friends & Family is consistently below threshold
- There were 13 breaches of the 12 hour trolley wait standard in July. All were as a result of waits for mental health beds within LCFT.
- The Referral to Treatment (RTT) target was not achieved at 87.6% and the total of ongoing pathways is above the year-end target at 33,176.
- RTT over 40wks has increased to 104.
- The cancer 62 day standard was not met in June.
- Cancer 14 day and breast symptomatic were not achieved in June.
- There were 2.5 breaches of the 104 day cancer wait standard.
- There were 3 breaches of the 28 day standard for operations cancelled on the day.
- Delayed discharges was above the 3.5% standard at 4.3% in July.

- Sickness rates remain above threshold at 4.8%
- The vacancy rate remains above threshold at 6.7%.
- Compliance against the Information Governance Toolkit and Appraisal (AFC staff) remains below threshold.
- Temporary costs as % of total pay bill remains above threshold at 10%

No Change

- All areas of core skills training except IG and Appraisal compliance are above threshold
- HSMR remains 'better than expected'.
- VTE risk assessment remains above threshold.

Introduction

This report presents an update on the performance for July 2019 and follows the NHS Improvement Single Oversight Framework. The narrative provides details on specific indicators under the five areas; Safe, Caring, Effective, Responsive, Well Led.

Key to Scorecard Symbols

Variation

	No significant variation or change in the performance data (Common cause variation)
	Significant improvement in the performance data that is not due to normal variation (Special case variation)
	Significant deterioration in the performance data that is not due to nornal variation (Special case variation)

Assurance

	The indicator may or may not meet the target - the variation in data sometimes meets the target and sometimes not
	The indicator will consistently meet the target. The variation in the data always falls within the target
	The indicator will consistently fail the target. The variation in the data always falls outside the target

	Indicator	Target	Actual	Variation	Assurance
Safe					
M64	CDIFF - HOHA	2	8		
M64.3	CDIFF - COHA	2	1		
M64.4	Cdiff Cumulative from April (HOHA& COHA)	18	24		
M65	MRSA	0	1		
M124	E-Coli (post 2 days)	4	7		
M155	P. aeruginosa bacteraemia (total post 2 days)	0	0		
M157	Klebsiella species bacteraemia (total post 2 days)	1	2		
M66	Never Event Incidence	0	0		
M67	Medication errors causing serious harm (Steis reported date)	0	0		
M68	Maternal deaths	0	0		
M64.2	C Diff per 100,000 Occupied Bed Days (HOHA)		29.6		
M69	Serious Incidents (Steis)		14		
M70	CAS Alerts - non compliance	0	0		
C28	Percentage of Harm Free Care	92%	99%		
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	98%		
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80.0%	92.0%		
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80.0%	104.6%		
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80.0%	98.5%		
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80.0%	118.5%		
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	2		
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0		
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	0		
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1		

	Indicator	Target	Actual	Variation	Assurance
Caring					
C38	Inpatient Friends and Family - % who would recommend	90%	99%		P
C31	NHS England Inpatients response rate from Friends and Family Test		52%		
C40	Maternity Friends and Family - % who would recommend	90%	97%		P
C42	A&E Friends and Family - % who would recommend	90%	84%		F
C32	NHS England A&E response rate from Friends and Family Test		22%		
C44	Community Friends and Family - % who would recommend	90%	98%		P
C15	Complaints – rate per 1000 contacts	0.40	0.29		P
M52	Mixed Sex Breaches	0	0		
Effective					
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Within Expected Levels	1.05		
M54	Hospital Standardised Mortality Ratio (DFI Indicative) (as at Apr-19)	Within Expected Levels	n/a		
M74	Hospital Standardised Mortality Ratio - Weekday (as at Apr-19)	Within Expected Levels	n/a		
M75	Hospital Standardised Mortality Ratio - Weekend (as at Apr-19)	Within Expected Levels	n/a		
M73	Deaths in Low Risk Conditions (as at Apr-19)	Within Expected Levels	n/a		
M159	Stillbirths	<5	3		
M160	Stillbirths - Improvements in care that impacted on the outcome		n/a		
M89	CQUIN schemes at risk				

	Indicator	Target	Actual	Variation	Assurance
Responsive					
C2	Proportion of patients spending less than 4 hours in A&E (Trust)	95.0%	80.1%		
C2ii	Proportion of patients spending less than 4 hours in A&E (Pennine A&E Delivery Board)	95.0%	81.5%		
M62	12 hour trolley waits in A&E	0	13		
M81	HAS Compliance	90.0%	93.1%		
M82	Handovers > 30 mins ALL	0	362		
M82.6P	Handovers > 30 mins ALL (NWAS Confirmed Penalty)	0	147		
C1	RTT admitted: percentage within 18 weeks		60.1%		
C3	RTT non- admitted pathways: percentage within 18 weeks		91.0%		
C4	RTT waiting times Incomplete pathways %	92.0%	87.6%		
C4.1	RTT waiting times Incomplete pathways Total	<29,619	33,176		
C4.2	RTT waiting times Incomplete pathways -over 40 wks		104		
C37.1	RTT 52 Weeks (Ongoing)	0	0		
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1.0%	0.7%		
C18	Cancer - Treatment within 62 days of referral from GP	85.0%	78.2%		
C19	Cancer - Treatment within 62 days of referral from screening	90.0%	87.5%		
C20	Cancer - Treatment within 31 days of decision to treat	96.0%	96.6%		
C24	Cancer - seen within 14 days of urgent GP referral	93.0%	88.1%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93.0%	89.7%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98.0%	98.4%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94.0%	95.5%		
C36	Cancer 62 Day Consultant Upgrade	85.0%	88.1%		
C25.1	Cancer - Patients treated > day 104	0	2.5		
M9	Urgent operations cancelled for 2nd time	0	0		
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	3		
M138	No.Cancelled operations on day		122		

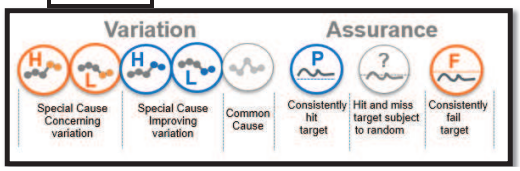
	Indicator	Target	Actual	Variation	Assurance
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.3%		
C16	Emergency re-admissions within 30 days		12.2%		
M90	Average LOS elective (excl daycase)		3.7		
M91	Average LOS non-elective		5.2		
Well Led					
M77	Trust turnover rate	12.0%	6.3%		
M78	Trust level total sickness rate (Reported 1 Month in arrears)	4.5%	4.8%		
M79	Total Trust vacancy rate	5.0%	6.7%		
M80.3	Appraisal (AFC)	90.0%	84.0%		
M80.35	Appraisal (Consultant)	90.0%	96.0%		
M80.4	Appraisal (Other Medical)	90.0%	98.0%		
M80.2	Safeguarding Children	90.0%	96.0%		
M80.21	Information Governance Toolkit Compliance	95.0%	94.0%		
F8	Temporary costs as % of total paybill	4.0%	10.0%		
F9	Overtime as % of total paybill	0.0%	0.0%		
F1	Adjusted financial performance (deficit) including PSF (£M)	6.7	(0.7)		
F1.1	Adjusted financial performance (deficit) excluding PSF (£M)	(7.0)	(3.8)		
F2	SRCP Achieved % (green schemes only)	100.0%	40.0%		
F3	Liquidity days	>(14.0)	(5.1)		
F4	Capital spend v plan	85.0%	102.0%		
F16	Finance & Use of Resources (UoR) metric - overall	3	3		
F18	Finance and UoR metric - capital service capacity	3	3		
F17	Finance and UoR metric - liquidity	3	2		
F19	Finance and UoR metric - I&E margin	1	3		
F20	Finance and UoR metric - distance from financial plan	1	2		
F21	Finance and UoR metric - agency spend	3	3		
F12	BPPC Non NHS No of Invoices	95.0%	98.3%		
F13	BPPC Non NHS Value of Invoices	95.0%	97.3%		
F14	BPPC NHS No of Invoices	95.0%	96.7%		
F15	BPPC NHS Value of Invoices	95.0%	99.2%		

NB: Finance Metrics are reported year to date.

SPC Control Limits

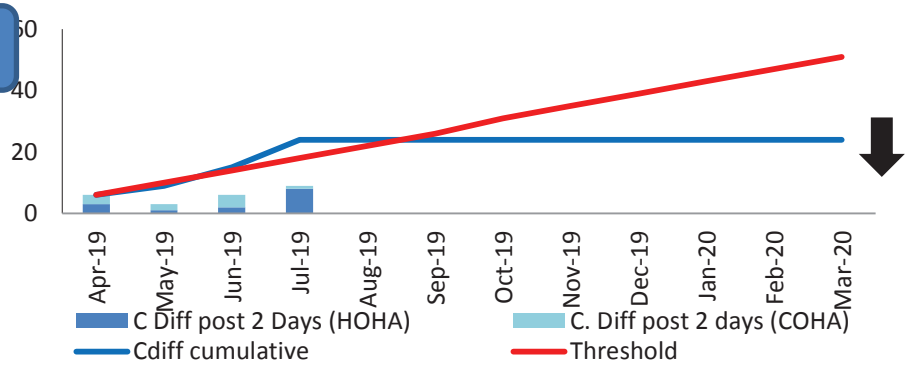
The data period used to calculate the SPC control limits is Apr 17 - Mar 19.

KEY



SAFE

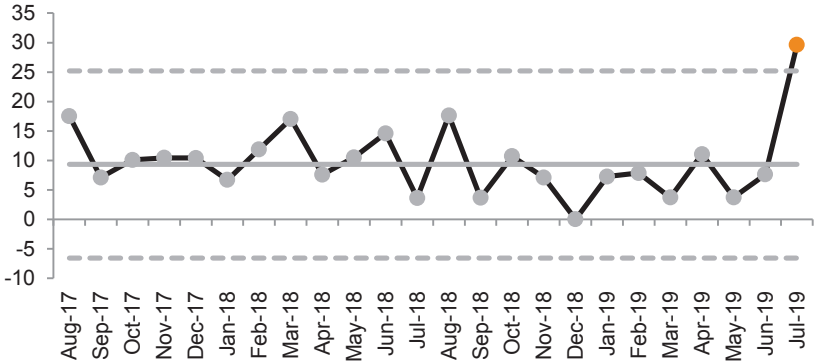
C Difficile



There was one post 2 day MRSA infection reported in July.

The objective for 2019/20 is no more than 51 cases of 'Hospital onset healthcare associated (HOHA)' /'Community onset healthcare associated (COHA)' . In 2019/20 there will be changes to the reporting algorithm. The number of days to identify hospital onset healthcare associated cases from ≥3 to ≥2 days following admission and adding a prior healthcare exposure element for community onset cases including day cases.

C Diff per 100,000 Occupied Bed Days (HOHA)

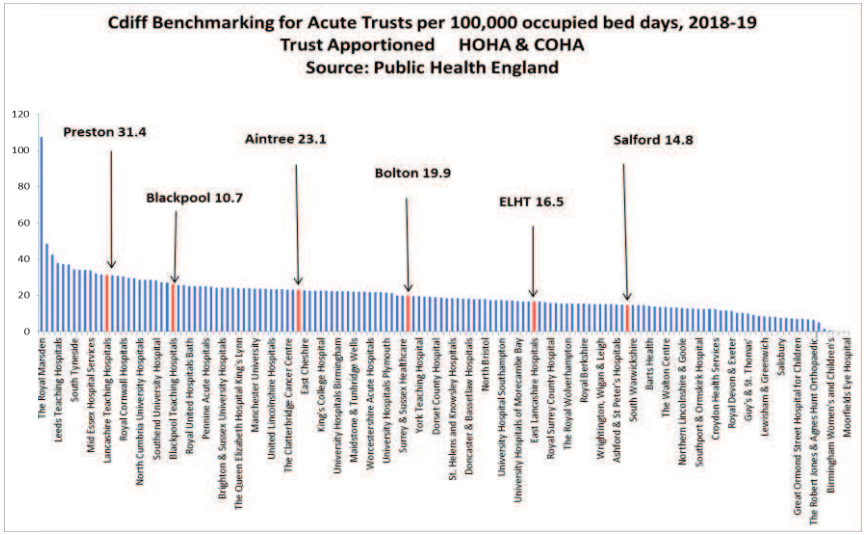


There were 9 Clostridium difficile toxin positive isolates identified in the laboratory in July, post 2 days of admission, of which 8 were 'Hospital onset healthcare associated (HOHA)' and 1 was 'Community onset healthcare associated (COHA)'.

The year to date cumulative figure is 24 against the trust target of 51. The detailed infection control report will be reviewed through the Quality Committee.

The rate of HOHA infection per 100,000 bed days is showing July was an exceptionally high month.

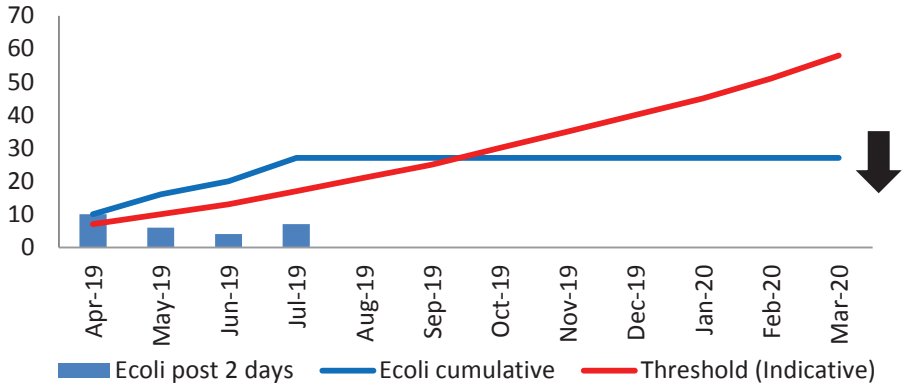
C Difficile benchmarking



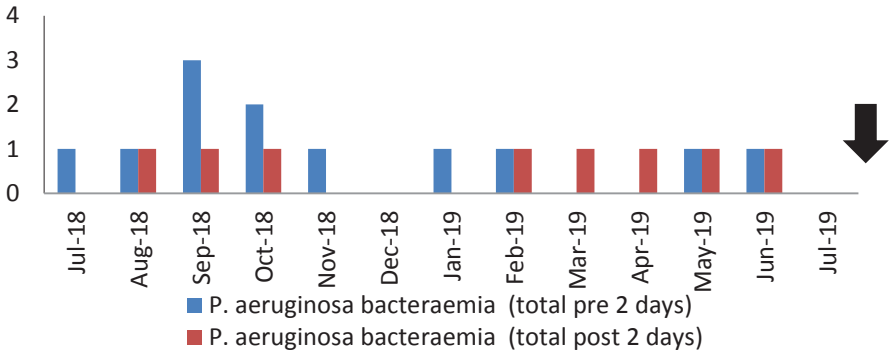
ELHT ranked 58th out of 148 trusts in 2018-19 with 16.5 HOHA & COHA clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 107.4 infections per 100,000 bed days.

SAFE

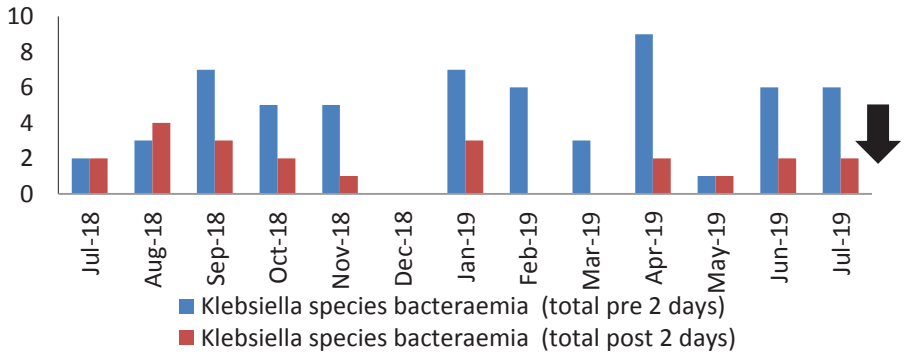
E. Coli



P.aeruginosa



Klebsiella



The Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021 has been revised and now is to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

The year end figure for 2018/19 was 66 cases, above the trajectory of 48.

This year's trajectory for reduction of E.coli has not yet been published, so an indicative trajectory of 58 has been included for information.

There were 7 E.coli bacteraemia detected in July, which is above the indicative monthly threshold.

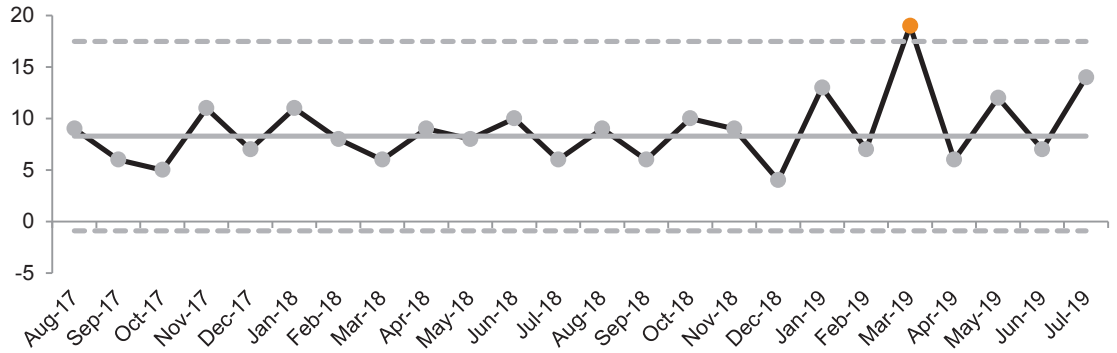
From April 2017, NHS Trusts must report cases of bloodstream infections due to *Klebsiella species* and *Pseudomonas aeruginosa* to Public Health England.

Surveillance will be undertaken in line with current requirements (e.g. E. coli bacteraemia). This surveillance will be carried out by the Infection Prevention and Control Team.

The work on catheter care, prevention of line infections, sepsis and improving hydration will help prevent healthcare associated bloodstream infections

SAFE

Serious Incidents



There were no never events reported in July.

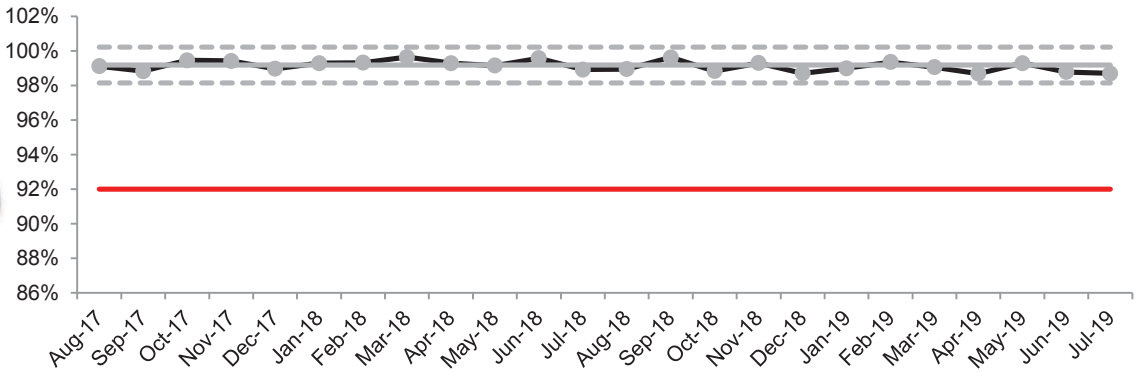
The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in July was 14 incidents.

The trend is not showing any significant change.

StEIS Category	No. Incidents
Pressure Ulcer	6
Treatment Delay	4
Treatment Delay – MH Breach 81 Hours	1
SJR2 – Pending Review	1
Surgical/Invasive procedure meeting SI criteria	1
Disruptive/Aggressive/Violent behaviour meeting SI criteria	1

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Patient Safety and Risk Assurance Committee.

% Harm Free Care from safety

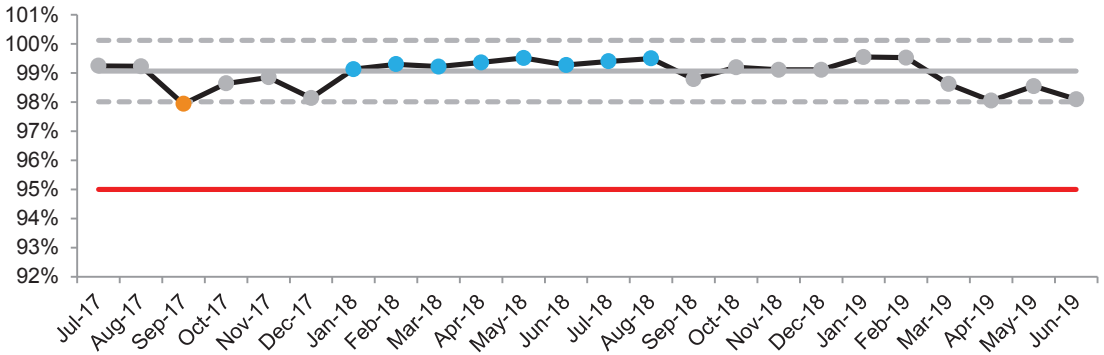


The Trust remains consistent with the percentage of patients with harm free care at 98.7% for July using the National safety thermometer tool.

The trend is showing no significant change.

SAFE

VTE assessment



The VTE assessment trend is showing normal variation and based on recent performance will consistently achieve the standard.

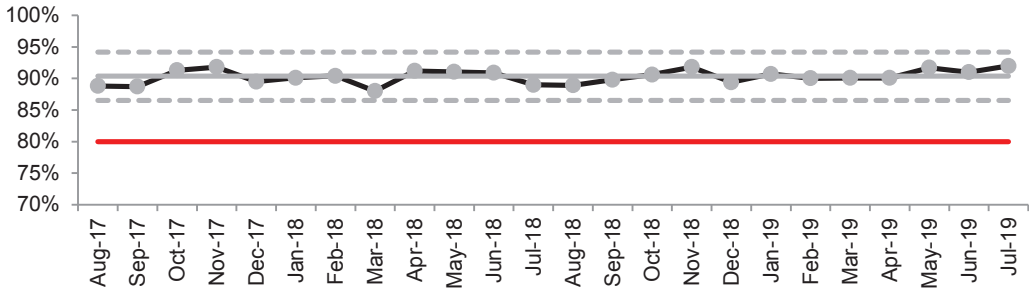
Pressure Ulcers

Pressure Ulcer - Cat 2 - Device related - developed/ deteriorated during ELHT care	1
Pressure Ulcer - Cat 2 - Developed / Deteriorated during care of ELHT	7
Pressure Ulcer - Cat 3 - Device related - developed / deteriorated during care of ELHT	0
Pressure Ulcer - Cat 3 - Developed / deteriorated during care of ELHT	1
Pressure Ulcer - Cat 4 - Device related - developed / deteriorated during the care of ELHT	0
Pressure Ulcer - Cat 4 - Developed / deteriorated during the care of ELHT	1
Pressure Ulcer - Deep tissue injury - Device related - developed / deteriorated during the care of ELHT	1
Pressure Ulcer - Deep tissue inury - developed / deteriorated during the care of ELHT	6
Pressure Ulcer - Unstageable - device related - developed / deteriorated under the care of ELHT	1
Pressure Ulcer - Unstageable - developed / deteriorated under the care of ELHT	4

For July we are reporting the current unvalidated pressure ulcer position, pending investigation, as follows:

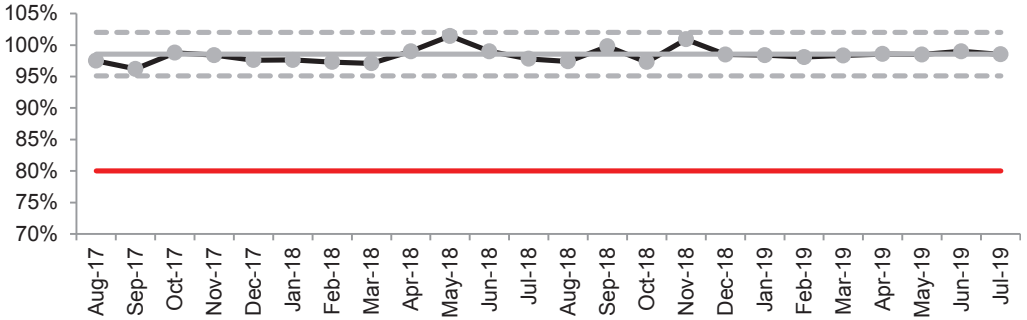
SAFE

Registered Nurses/ Midwives - Day



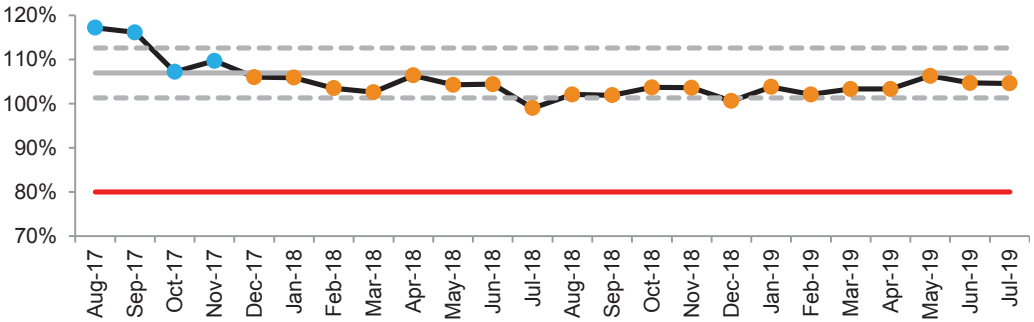
The average fill rate for registered nurses/ midwives during the day is showing no significant change and based on current variation will consistently be above threshold.

Registered Nurses/ Midwives - Night



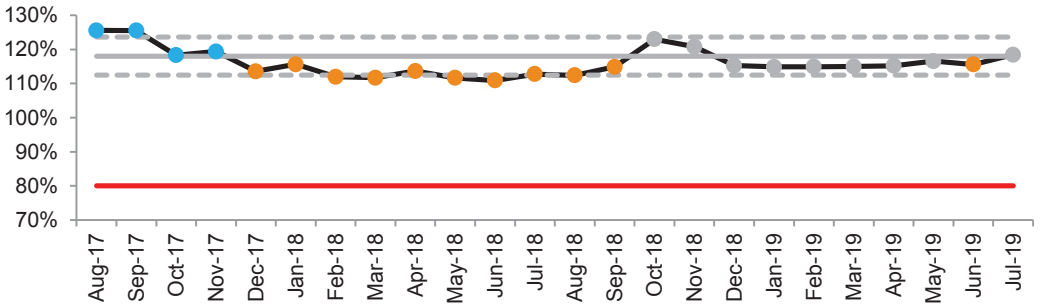
The average fill rate for registered nurses/ midwives at night is showing no significant change and based on current variation will consistently be above threshold.

Care Staff - Day



The average fill rate for care staff during the day is showing a significant reduction, however the indicator remains above the threshold and based on current variation will consistently be above the threshold.

Care Staff - Night



The average fill rate for care staff at night is showing normal variation. The indicator remains above the threshold and based on current variation will consistently be above the threshold.

Nursing and midwifery staffing in July 2019 continued to be a challenge. The causative factors remain as in previous months, compounded by escalation areas being open, pressures within the emergency department, vacancies, sickness and the ability to fill all requests through ELHT internal bank or via framework agency. Safe care (acuity data) is utilised when considering safe staffing and the redeployment of staff and safe staffing is monitored throughout the day.

There were 2 areas below the 80% for registered nurses on day shifts, all were due to lack of co-ordinator presence which is in addition to safe staffing levels.

It should be noted that actual and planned staffing does not denote acuity, dependency, the amount of women in labour or bed occupancy. The divisions consistently risk asses and flex staffing resources to ensure safety is maintained. Of the staffing DATIX incidents reported the divisions have given assurance that no harm has been identified as a consequence of staffing.

Average Fill Rate

	Average Fill Rate				CHPPD		Number of wards < 80 %			
	Day		Night				Day		Night	
Month	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses /midwives (%)	Average fill rate - care staff (%)	Midnight Counts of Patients	Care Hours Per Patient Day (CHPPD)	registered nurses/ midwives	care staff	registered nurses/ midwives	care staff
Jul-19	92.0%	104.6%	98.5%	118.5%	27,020	8.86	2	0	0	1

Red Flag Incidents

There was 1 red flag incident reported in the red flag category of DATIX (for nursing) in July 2019, less than 2 registered nurses on duty. This relates to Hartley ward on night duty when an agency nurse did not arrive as expected, which resulted in a delay of 4 hours getting another registered nurse to the unit. No harm was identified as a consequence. An extra support worker was sent whilst a registered nurse was identified to send to Hartley. Staffing in the Trust on this particular night was extremely challenging.

In MEC, 3 incident report were completed where staff shortages was identified to have delayed nursing care. These incidents **should** have been reported under the “Red Flag” incident reporting structure within DATIX. The division has been reminded to ensure staff are aware of this and understand the categories for reporting staffing issues within DATIX.

C2 – at 00:30 a registered nurse was moved leaving 2 trained nurses on the ward. No harm was reported, however there was a delay in patients receiving medication, patient observations and care were performed late

C7 – overnight the ward had its usual number of staff and an additional HCA, however due to high acuity there was a delay in administering medication and performing patient observations. Staff didn't take their unpaid bread, no harm was identified

CCU – overnight a patient fell, no harm identified. A HCA for 1:1 supervision had been authorised, unfortunately this shift was not filled, but the patient in question was supervised by the registered nurse overnight despite lack of HCA availability. The patient that sustained a fall with no harm was another patient who was not deemed at risk of falling and was independent, it is anticipated that this would have occurred despite staffing levels

Actions taken to mitigate risk:

- Safe staffing conference at 10 am followed up with meetings through out the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours, utilising acuity and dependency (Safe Care)
- Extra health care assistant shifts are utilised to support registered nurse gaps if required
- On going recruitment.
- Global learners continue to arrive
- A further cohort of trainee nurse associates has been recruited to.

Family Care July 2019

Maternity

July has been an extremely challenging month for maternity staffing. Staff Sickness and absence for the month remains high with robust management plans in place to ensure safe staffing levels at all times. This is reflected via the maternity safety huddles which take place four times within a 24 hour period. Similar to June on a couple of occasions Blackburn Birth centre services have been suspended for births to support staffing at the Lancashire women and new-born centre in Burnley, this midwifery deployment will only occur if bank shifts are unfilled and the acuity and activity is risk assessed in line with the safe nursing and midwifery staffing escalation policy (ELHT/C135 v1.1) to achieve safe staffing levels.

Maternity Services - only

Five midwifery red flags were reported in the month of July, three reviewed confirmed as staffing levels under expected levels.
1 Staffing issue – Inability to attend rostered Mandatory training (PROMPT). *No harm - Impact not prevented.*
1 Staffing issue – Unable to reliably carry out intentional rounding. *No harm - Impact prevented.*
3 Staffing issues – Staff shortage midwives. *No harm - Impact prevented.*

One reported - Inability to attend rostered mandatory training- This is a true reflection although occurred in an outpatient area (Antenatal Clinic- ANC) where training was cancelled to support a safe level of staffing following unexpected sickness.

One reported - Unable to reliably carry out intentional rounding – (patient vital signs not assessed or recorded as outlined in the care plan). This is a true reflection, although the ward manager was redeployed to cover the duty to achieve safe staffing levels following unexpected sickness when this event occurred.

Some staffing gaps were covered by using bank; all unfilled duties were out to bank. Redeployment of midwives, maternity support workers and health care assistant to other areas have covered staffing gaps on days of lower acuity/activity to support the areas of higher acuity/activity. The escalation action card following sudden acute Midwifery staffing shortfalls was followed on the days of all midwifery red flag events and daily where appropriate in the month of July.

No harm was caused.

There was appropriate escalation and implementation of the escalation policy when acuity and activity was high. Workload was prioritised and staff moved to the areas with the highest workload. All area leads, shift co-ordinators, Matron on Call, and Night Manager were informed of plans and communication with all disciplines involved in care and service delivery was good throughout

Maternity Midwife to Birth Ratio

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Staffed to full Establishment	01:29	01:27	01:26	01:28	01:27	01:27	01:27	01:27	01:28	01:27	01:29	01:27.5
Excluding mat leave and vacancies	01:30	01:28.4	01:27.5	01:29	01:28	01:28	01:28	01:28	01:29	01:28	Staffed up to mat leave	01:28.7
With gaps filled through ELHT Midwife staff bank	01:29	01:27	01:26	01:28	01:27	01:27	01:27	01:27	01:28	01:27	01:28	01:27.7
	Bank Usage 9.28 WTE	Bank Usage 9.5 WTE	Bank Usage 6.5WTE	Bank Usage 5.74WTE	Bank Usage 5.8WTE	Bank Usage 7.0WTE	Bank Usage 4.8WTE	Bank Usage 6.3WTE	Bank Usage 5.17 WTE	Bank Usage 7.27 WTE	Bank Usage 9 WTE	Bank Usage 7.94 WTE

The staffing figures do not reflect how many women were in labour or acuity of areas.
The midwife to birth ratio should be 1:28 for the period 01/08/18 - 31/07/19

Acuity and activity has been reviewed more frequently via additional safe staffing huddles in view of staffing pressures to ensure gaps for the pending days are covered in view of unexpected sickness, a focus on competencies and skillset is paramount at these huddles with effective communication taking place with the individual staff members prior duty as opposed to attending for duty to then be informed of redeployment.

SAFE

This has not taken place in all cases, however promoted as best practice within the maternity services.

A multi professional team approach remains embedded as part of the safety huddles which take place on the Central Birth Suite with representation from all areas , these safety huddles host a helicopter view of maternity services at ELHT.

Some of the professional judgment midwifery hours have been recruited with start dates allocated for August and September advert out at present for remaining hours. Professional judgment MSW/HCA hours are all recruited with start dates pending.

NICU- No exceptions reported. Some periods of unexpected sickness and closure of the Neonatal unit on three occasions had an impact on safe staffing levels where acuity and activity was high. The escalation/ British association of perinatal medicine (BAPM) tool is used to risk assess the acuity/activity in order to determine the request for bank usage, if unfilled the next option has been to use agency. All duties have reflected safe staffing levels to meet the requirements of the tool.

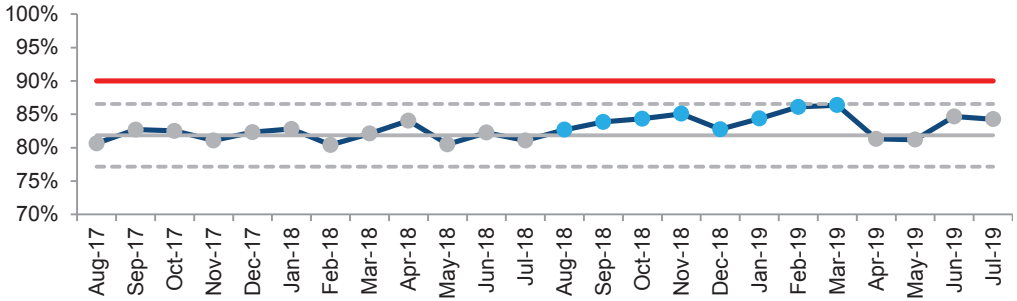
Paediatrics- No exceptions reported. Paediatrics continues in the month of July to use bank and agency nurse staffing to care for a children requiring 1-1 care. Staffing levels remain a constant challenge with sickness, vacancies and maternity leave. Acuity and activity is closely monitored and recorded three times throughout the day with reference to safe staffing levels with appropriate plans made point prevalent. Recruitment and selection processes are ongoing. Professional judgment nursing gaps have all been recruited to with three posts remaining only, starts dates are mid-September. Professional judgment HCA gaps are in the process of being recruited to with bank shifts being the plan to cover in the interim period.

Please see Appendix 2 for UNIFY data and nurse sensitive indicator report

CARING

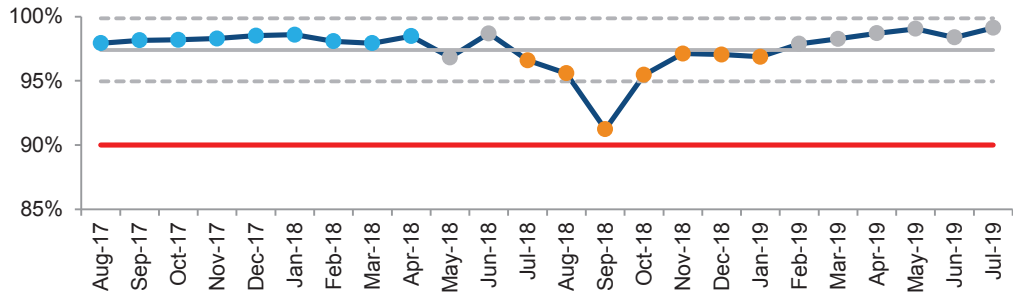
These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The threshold has been set at 90% since April 2018.

Friends & Family A&E



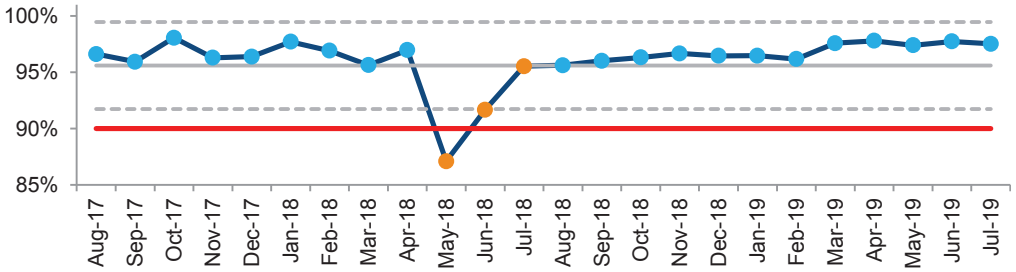
A&E scores show normal variation following a period of significant improvement since August 2018. Based on current variation this indicator is not capable of hitting the target.

Friends & Family Inpatient



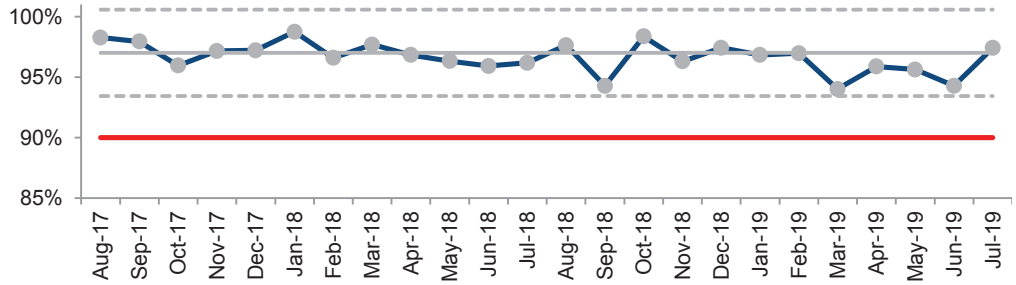
Inpatient scores show no significant change after a period of significant low scores ending in February 19 . Based on current variation this indicator should consistently hit the target.

Friends & Family Community



Community scores show significant improvement for the past 12 months. Based on current variation this indicator should consistently hit the target.

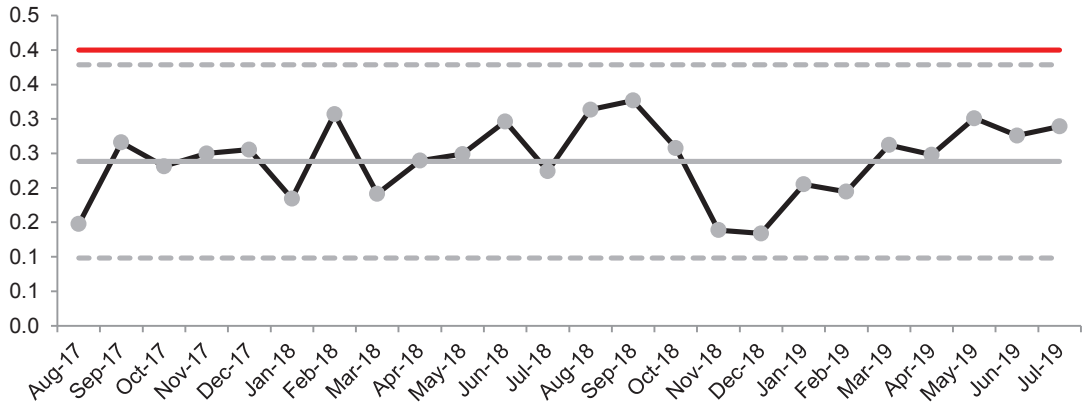
Friends & Family Maternity



Maternity scores show no recent significant change and based on current variation this indicator should consistently hit the target.

CARING

Complaints per 1000 contacts



The Trust opened 35 new formal complaints in July.
The number of complaints closed was 37.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts. The Trust on average has approximately 116,000 patient contacts per calendar month.

For July the number of complaints received was 0.3 Per 1,000 patient contacts.

The trend is showing no significant change and based on current variation will consistently achieve the target.

Patient Experience

June 2019 Totals	Dignity	Information	Involvement	Quality	Overall
	Average Score %	Average Score %	Average Score %	Average Score %	Average Score %
Trust	96	91	94	94	94
Medicine and Emergency Care	94	90	93	94	93
Community and Intermediate Care Services	95	94	93	96	94
Surgery	94	90	92	93	92
Family care	99	94	97	95	96
Diagnostic and Clinical	95	95	90	93	93

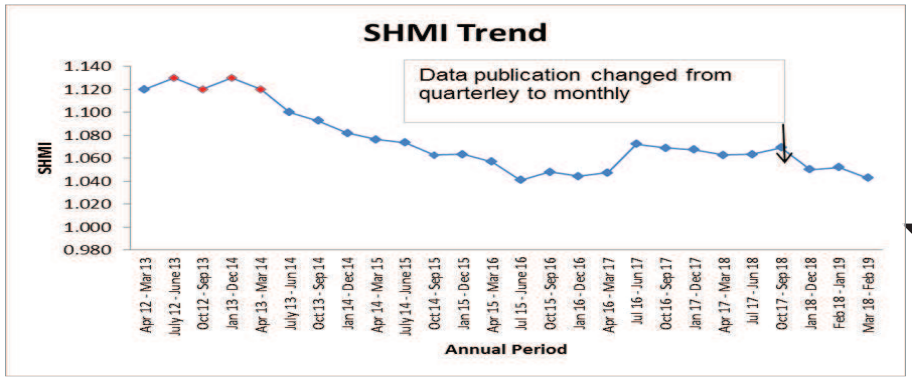
The table demonstrates divisional performance from the range of patient experience surveys in July 2019.

The threshold is a positive score of 90% or above for each of the 4 competencies.

The overall Trust performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies.

EFFECTIVE

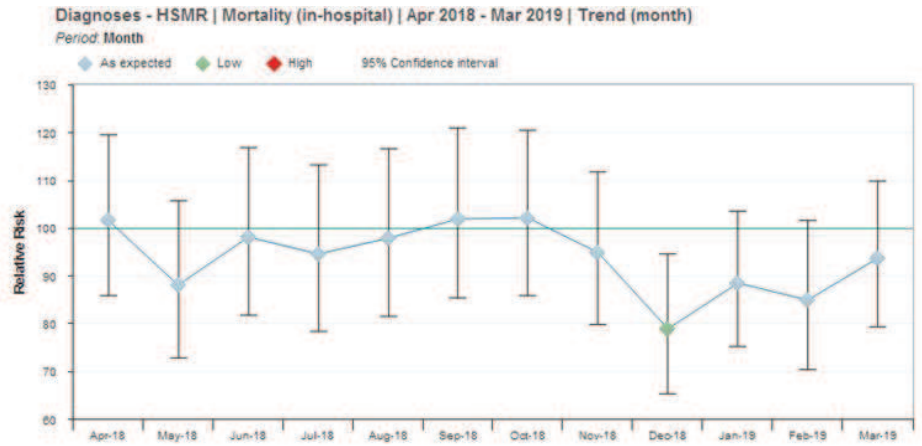
SHMI Published Trend



Dr Foster HSMR rolling 12 month

	HSMR Rebased on latest month Apr 18 – Mar 19 (Risk model Dec 18)
TOTAL	93.4 (CI 88.9 – 98.1)
Weekday	93.2 (CI 88.0 – 98.7)
Weekend	93.9 (CI 85.0 – 103.5)
Deaths in Low Risk Diagnosis Groups	97.7 (CI 60.0 – 149.0)

Dr. Foster HSMR monthly Trend



The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission for the period April 18 to March 18 has remained within expected levels at 1.04, as published in July 19.

The latest indicative 12 month rolling HSMR (April 18 – March 19) remains 'significantly better than expected' at 93.4 against the monthly rebased risk model.

The weekday HSMR is also 'significantly better than expected'

Septicaemia continues to alert on the HSMR and the SHMI.

There are currently three SHMI groups with significantly high relative risk scores. These are being investigated through the mortality steering group and each have a nominated clinical lead and an associated action plan.

Two further learning disability deaths were reviewed through the Learning Disability Mortality Review Panel. All cases have been reported to the LeDeR National Programme. The LDMR Panel continue to meet on a monthly basis as required to review cases.

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

Structured Judgement Review Summary

The new structured judgement review process was launched at the beginning of December 2017 for deaths meeting specified criteria. A team of reviewers have been trained on how to complete SJR's and are now undertaking the monthly reviews.

The table below shows a breakdown of SJR's completed and the scores allocated. Any death allocated a SJR score of 1 or 2 will have a stage 2 SJR completed.

The stage 2 SJR reviewer will determine whether or not any lapses in care may have contributed to the death and if so a SIRI and RCA will be triggered.

	Month of Death																		
Stage 1	pre Oct 17	Oct 17 - Mar 18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	TOTAL
Deaths requiring SJR (Stage 1)	46	212	41	26	21	26	19	27	21	15	15	21	4	8	23	19	26	17	587
Allocated for review	46	212	41	26	21	26	19	27	21	15	15	21	4	8	23	19	26	17	587
SJR Complete	46	212	41	26	21	25	19	27	20	14	14	19	3	8	21	10	13	8	547
1 - Very Poor Care	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
2 - Poor Care	8	19	2	2	4	2	0	1	3	1	2	2	0	2	1	4	3	1	57
3 - Adequate Care	14	68	10	9	1	9	7	10	4	5	4	4	0	3	5	3	2	4	162
4 - Good Care	20	106	26	11	13	11	9	14	12	7	6	12	3	2	13	3	8	3	279
5 - Excellent Care	3	18	3	4	3	3	3	2	1	1	2	1	0	1	2	0	0	0	47
Stage 2																			
Deaths requiring SJR (Stage 2)	9	20	2	2	4	2	0	1	3	1	2	2	0	2	1	4	3	1	59
Deaths not requiring Stage 2 due to undergoing SIRI or similar	3	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Allocated for review	6	18	2	2	4	2	0	1	3	1	2	2	0	2	1	3	2	0	51
SJR-2 Complete	6	18	2	2	4	2	0	1	2	1	2	2	0	2	1	3	2	0	50
1 - Very Poor Care	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
2 - Poor Care	3	6	1	0	0	0	0	1	0	1	1	1	0	1	1	1	1	0	18
3 - Adequate Care	2	10	1	1	4	2	0	0	2	0	1	1	0	1	0	2	1	0	28
4 - Good Care	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
5 - Excellent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

	pre Oct 17	t 17 - Mar	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Total
stage 1 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
stage 1 requiring completion	0	0	0	0	0	1	0	0	1	1	1	2	1	0	2	9	13	9	40
Backlog	0	0	0	0	0	1	0	0	1	1	1	2	1	0	2	9	13	9	40
stage 2 requiring allocation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	3
stage 2 requiring completion	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Backlog	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1	4

EFFECTIVE

Commissioning for Quality and Innovation (CQUIN)

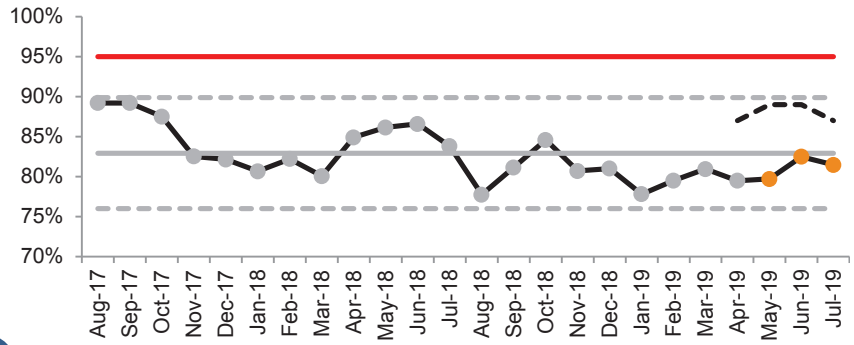
in 2019/20 the Trust is participating in the following 5 national CQUIN schemes as agreed with the CSU.

1. NHS Staff Health and Wellbeing - Staff Flu Vaccinations
2. Alcohol and Tobacco Brief advice
3. Three High Impact interventions to prevent Hospital Falls
4. Antimicrobial Resistance –Urinary Tract Infections and Antibiotic Prophylaxis for Elective Colorectal Surgery
5. Same Day Emergency Care –Pulmonary Embolus/ Tachycardia with Atrial Fibrillation/ Pneumonia

Clinical Effectiveness Committee will seek assurance that schemes are in progress and on track for delivery with timescales.

RESPONSIVE

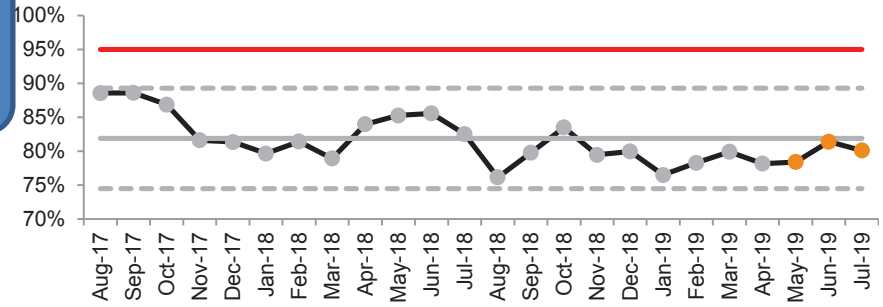
A&E 4 hour standard % performance -



Overall performance against the 'Pennine A&E Delivery Board' Accident and Emergency four hour standard was 81.5% in July, which remains below the 95% threshold.

The trend is showing statistical deterioration and based on current variation is not capable of hitting the target.

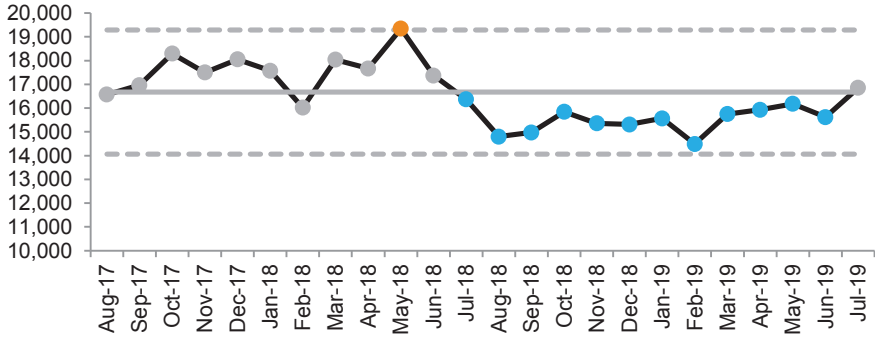
A&E 4 hour standard % performance - Trust



Performance against the ELHT four hour standard was 80.1% in July.

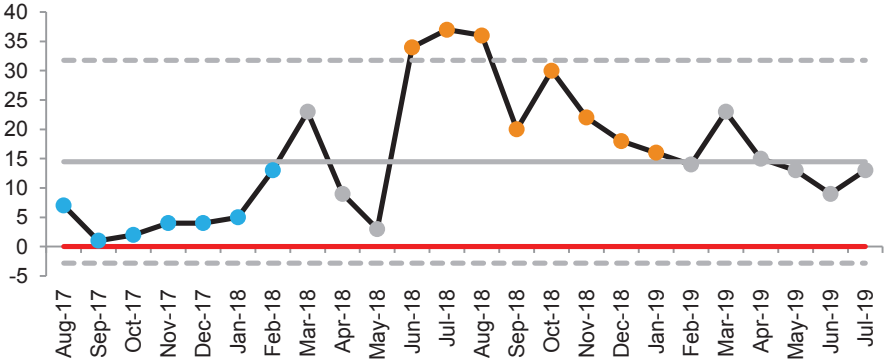
The national performance was 86.5% in July (All types) with 3 out of 119 reporting trusts with type 1 departments achieving the 95% standard. (Field testing sites excluded)

A&E Attendances - Trust



The number of attendances during July was 16,851 and the trend is showing normal variation, following a period of significant reduction in attendances since June 18, when the HAC closed.

12 Hr Trolley Waits

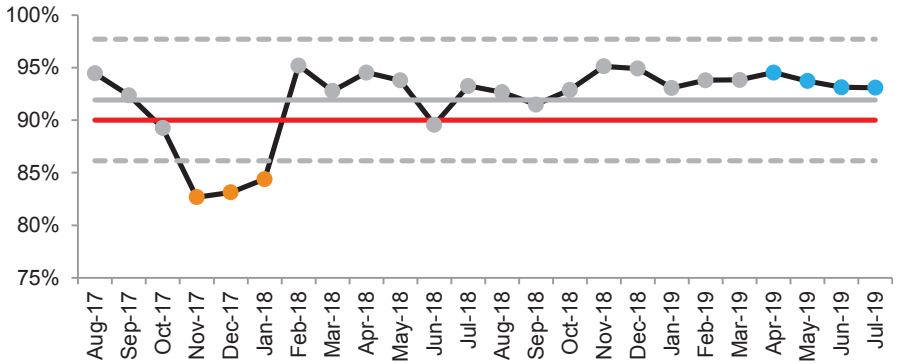


There were 13 reported breaches of the 12 hour trolley wait standard from decision to admit during July. All were mental health breaches. Rapid review timelines are completed in accordance with the NHS England Framework and a root cause analysis will be undertaken.

The trend is showing normal variation following a period of significantly higher numbers.

RESPONSIVE

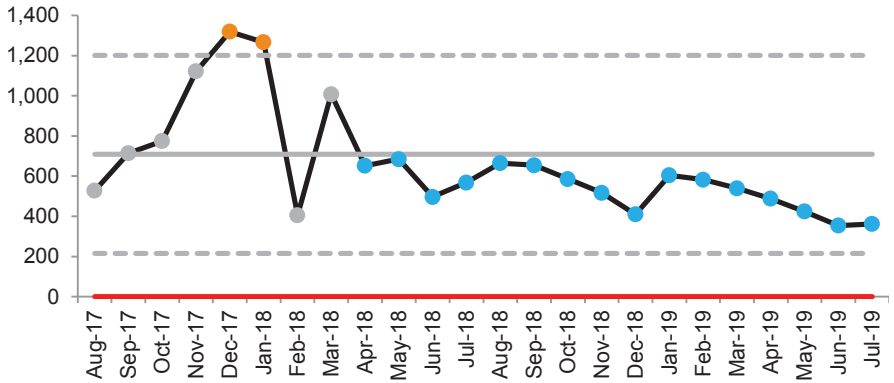
HAS Compliance



The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 93.1% in July, which is above the 90% threshold.

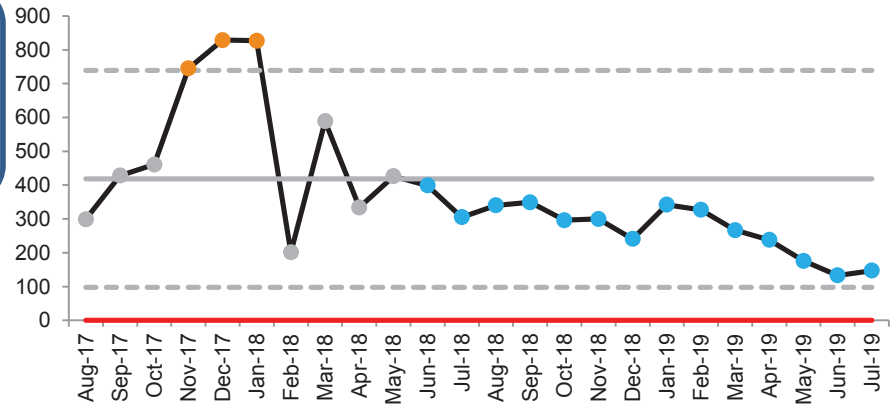
The trend is showing significant improvement, however based on current variation, the target is still at risk of failure.

Ambulance Handovers - >30Minutes



The number of handovers over 30 minutes is showing significant improvement, with 362 reported for July.

Ambulance Handovers - HAS Confirmed Penalty >30Minutes



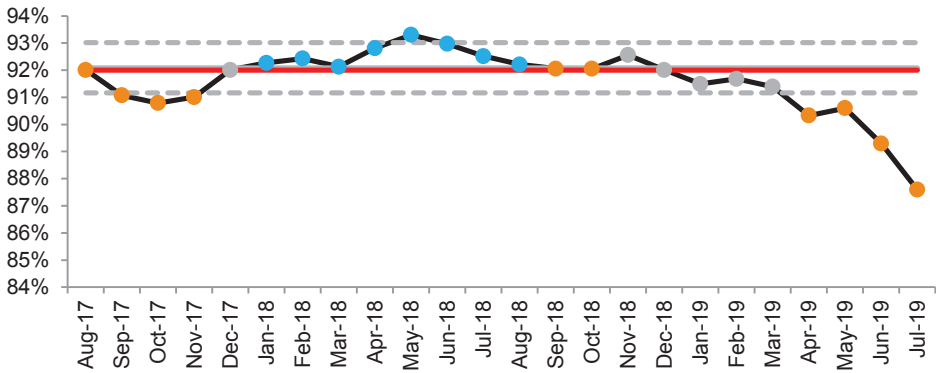
The validated NWAS penalty figures are reported as at July as;- 115 missing timestamps, 134 handover breaches (30-60 mins) and 13 handover breaches (>60 mins).

The trend is showing significant improvement, however based on current variation, the indicator is not capable of hitting the target.

The full action plan is monitored through the Finance & Performance Committee & the A&E Delivery Board.

RESPONSIVE

RTT Ongoing %

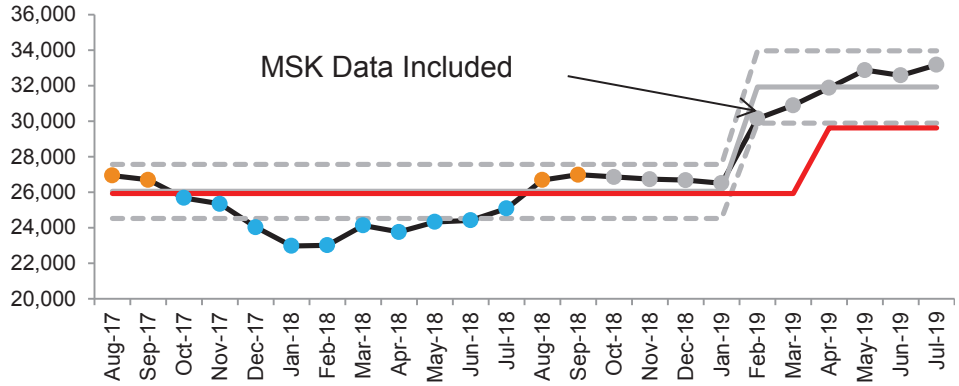


The 18 week referral to treatment (RTT) % ongoing position was not achieved in July with 87.6% patients, waiting less than 18 weeks to start treatment at month end.

The trend is showing significant deterioration in the last 4 months and based on current variation this indicator is at risk of failing the target.

The latest published figures from NHS England show continued failure of the ongoing standard nationally (reported 1 month behind), with 86.3% of patients waiting less than 18 weeks to start treatment in June.

RTT Total Ongoing

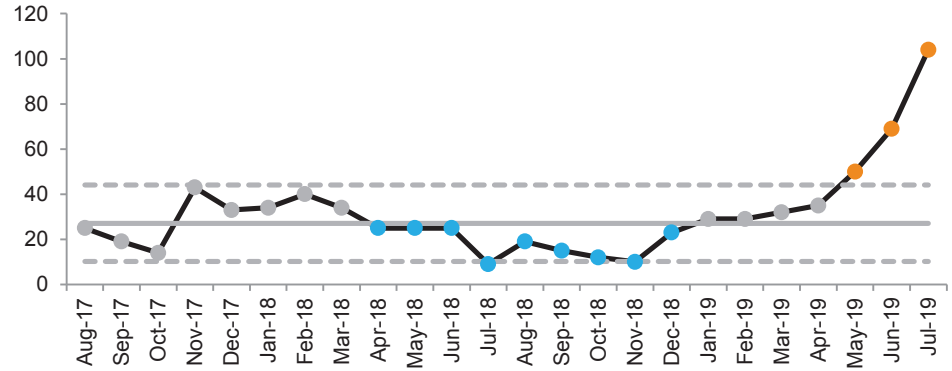


The total ongoing RTT pathways is showing normal variation in total numbers ongoing at the end of the month, following the inclusion of additional patients from the MSK service, from February 2019.

The target has been revised for 2019/20 to reduce the total to less than 29,619 by end of March 2020.

The rebased trend shows the indicator is at risk of not achieving this reduction.

RTT Total Over 40 wks

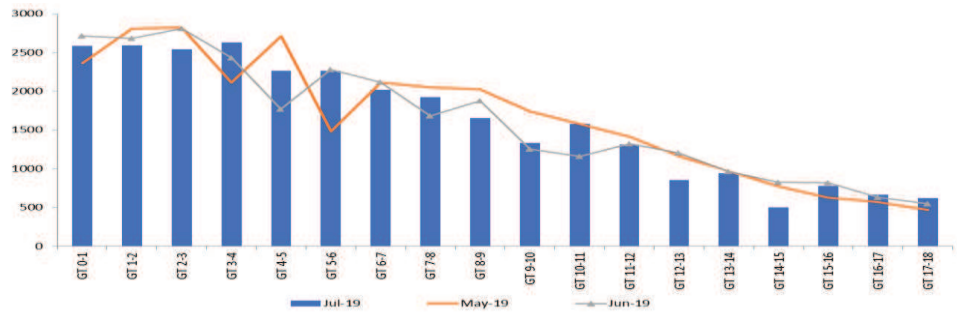


The number of pathways over 40wks has increased significantly in July with 104 patients waiting over 40 wks at month end.

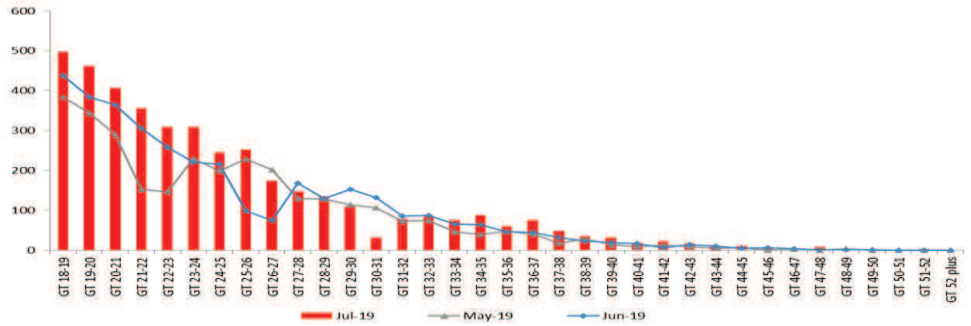
There were no patients waiting over 52 weeks at the end of July.

RESPONSIVE

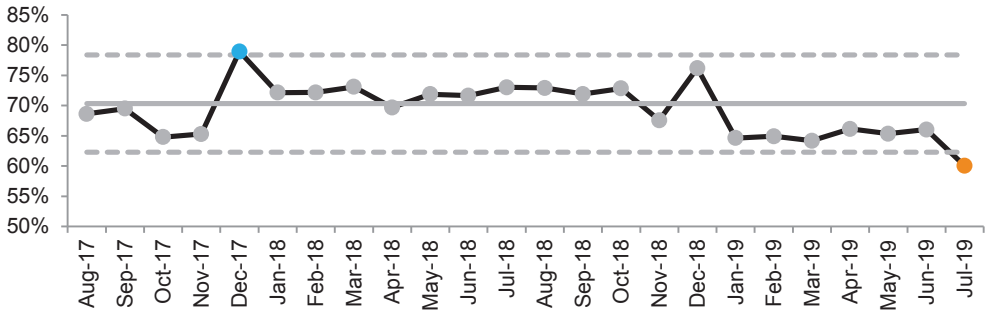
RTT Ongoing 0-18 Weeks



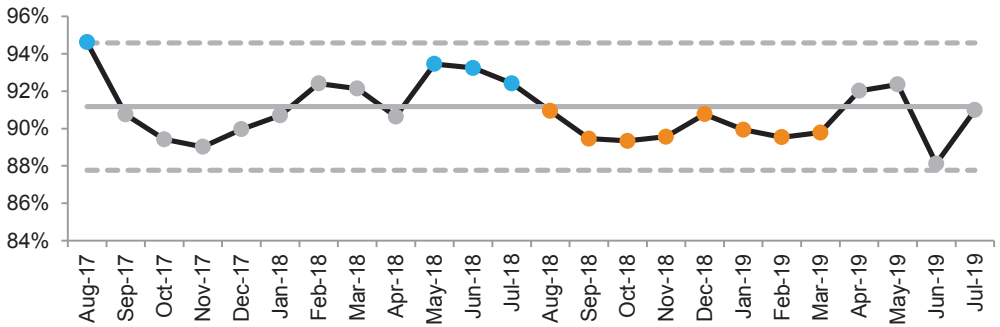
RTT Over 18 weeks



RTT Admitted



RTT Non-Admitted



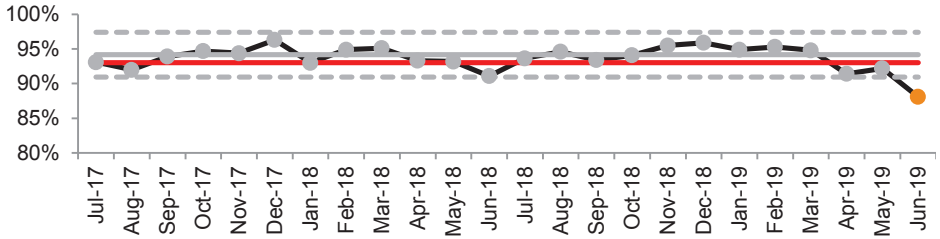
The bar charts show the numbers of RTT ongoing pathways by weekband, compared with previous 2 months.

Although no longer a national target, the proportion of admitted and non-admitted patients is included for information.

The trend for RTT admitted is now showing significant deterioration, whilst the non-admitted trend is showing normal variation.

RESPONSIVE

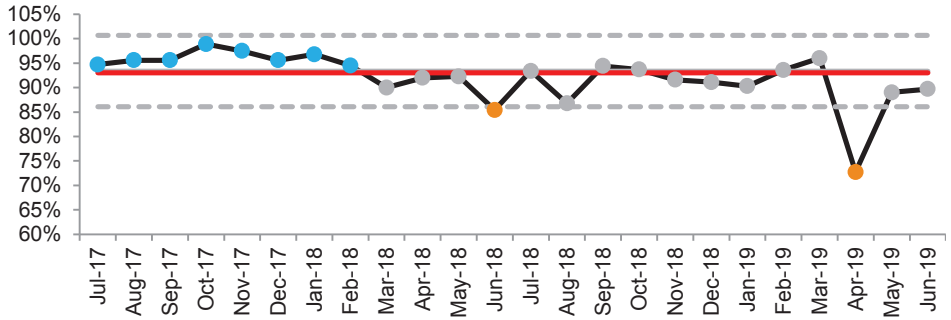
Cancer 2 Week



The cancer 2 week wait for GP referrals standard was not achieved in June at 88.1%, below the 93% threshold.

The trend is showing significant deterioration and based on current variation, the indicator is at risk of failing the standard.

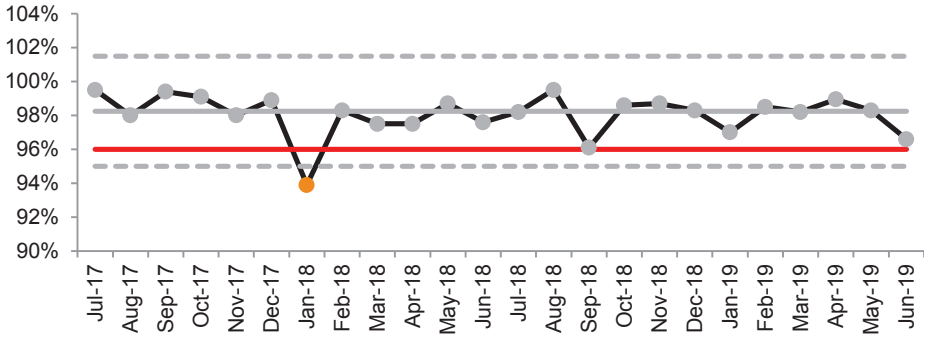
Cancer 2 Week - breast



The 2 week breast symptomatic standard was not achieved in June at 89.7%, below the 93% threshold. Audits has shown that appointments are available within the 14 days and failure to meet the standard is driven by patient choice.

The trend shows normal variation for June and based on current variation this indicator is at risk of failing the standard.

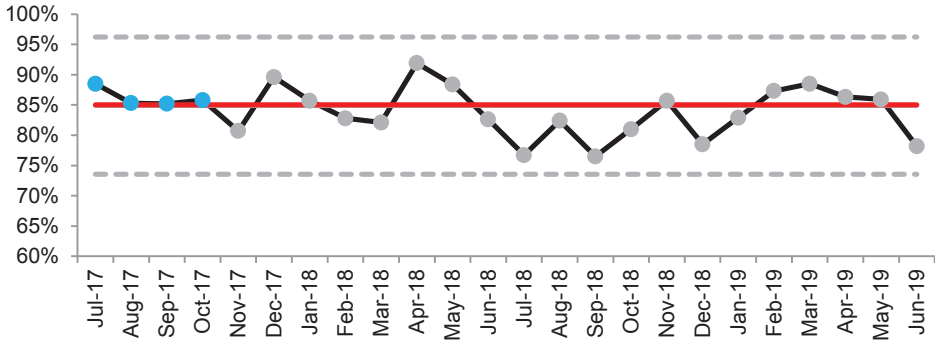
Cancer 31 day



The 31 day standard was achieved in June at 96.6%, above the 96% threshold.

The trend is showing no significant change and based on current variation may occasionally fall below the standard.

62 Day Cancer

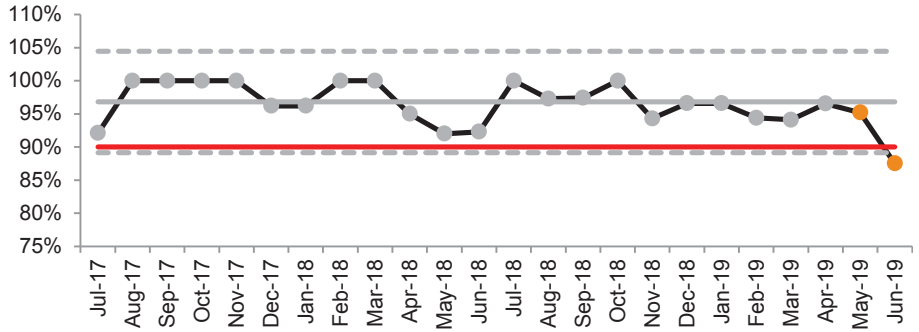


The 62 day cancer standard was not achieved in June at 78.2% below the 85% threshold.

The trend is showing normal variation and based on the current variation, the indicator is at risk of not meeting the standard.

RESPONSIVE

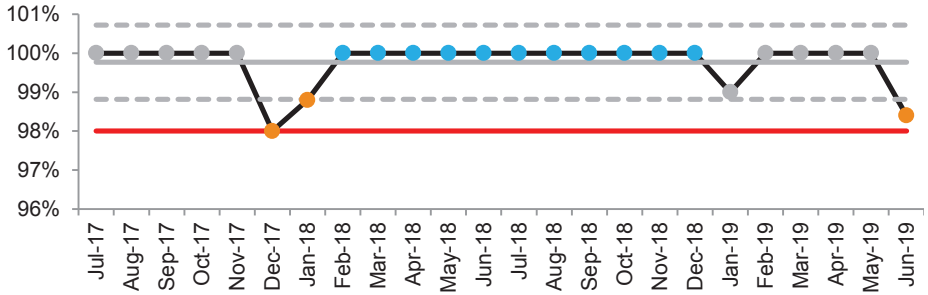
62 Day Screening



62 day screening performance was not achieved in June at 87.5%, below the 90% threshold.

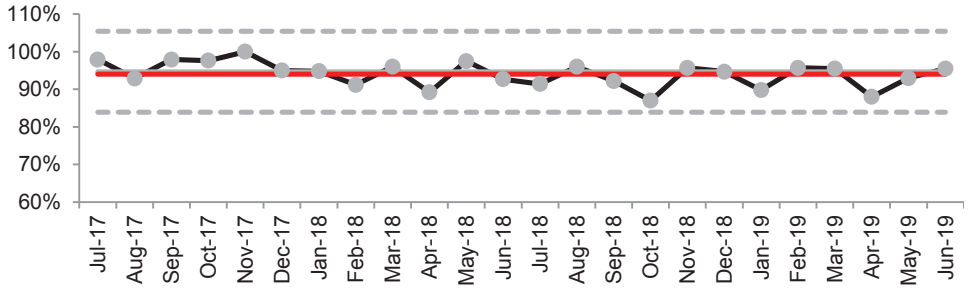
The trend is showing a deterioration in performance and based on current variation may occasionally fall below standard.

Cancer - Subsequent treatment within



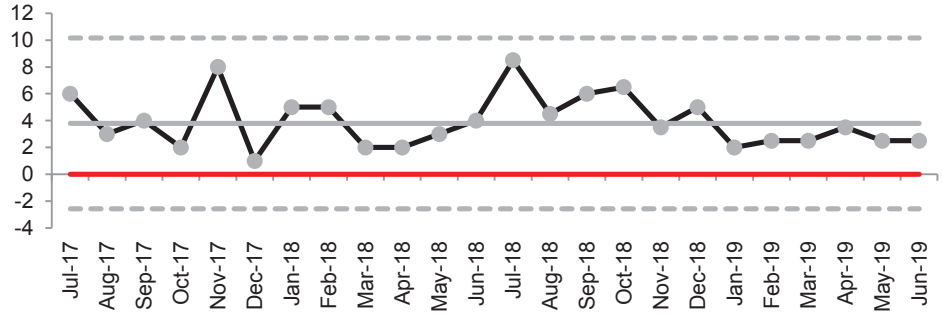
The subsequent treatment - drug standard was met in June at 98.4%. The trend shows a significant drop in June, however based on the current variation, the indicator will consistently achieve the standard.

Cancer - Subsequent treatment within 31 days (Surgery)



The subsequent treatment - surgery standard was met in June at 95.5%, above the 94% standard. The trend shows no significant change and based on the current variation, the indicator is at risk of falling below threshold.

Cancer Patients Treated > Day 104

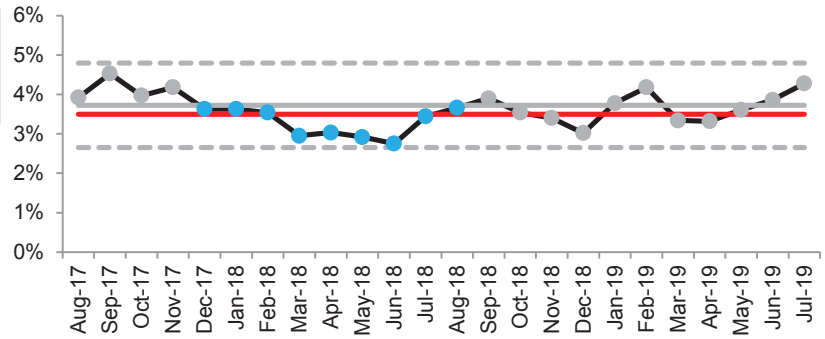


There were 2.5 breaches allocated to the Trust, treated after day 104 in June and will have a detailed root cause analysis undertaken by the clinical director for cancer with the cancer oncology directorate manager liaising with the Consultants involved in the pathway as required.

The trend is showing no significant change.

RESPONSIVE

Delayed Discharges per 1000 bed days

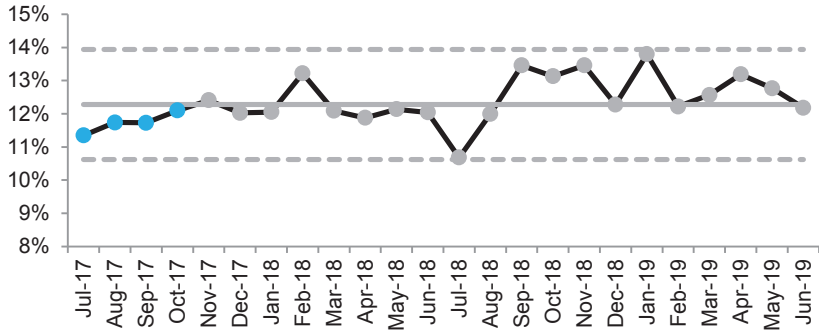


The proportion of delays reported against the delayed transfers of care standard was 4.3% for July, above the 3.5% threshold.

The trend is showing no significant change and based on current variation this indicator may or may not achieve the target.

There is a full action plan which is monitored through the Finance & Performance Committee.

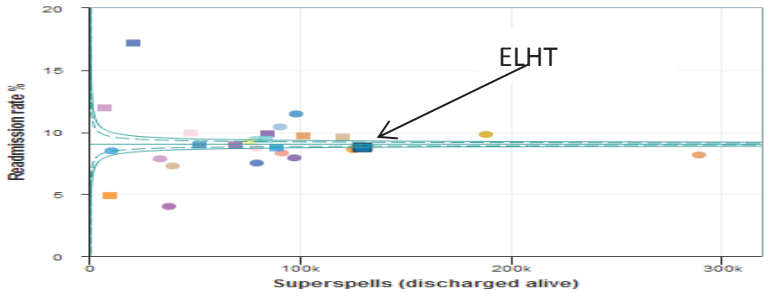
Emergency Readmissions



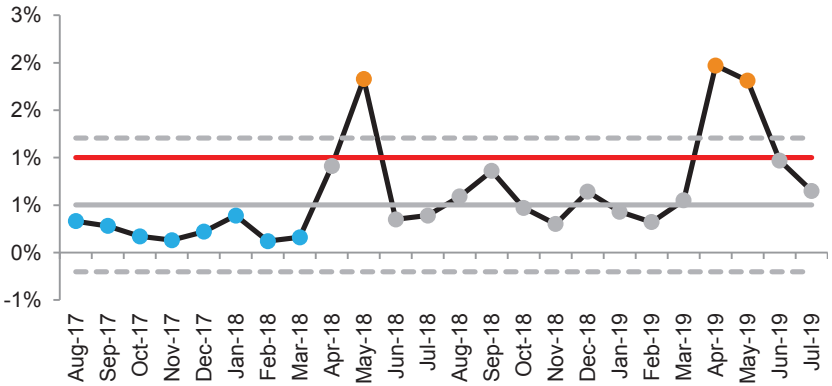
The emergency readmission rate trend is showing no significant change.

Dr Foster benchmarking shows the ELHT readmission rate is below the North West average.

Readmissions within 30 days vs North West - Dr Foster



Diagnostic Waits



In July 0.7% of patients were waiting longer than 6 weeks for a diagnostic procedure, which is below the 1% threshold.

The trend is showing a return to normal variation following a 2 month period of significantly high levels and based on current variation this indicator is at risk of failing the target.

Nationally, the performance is still failing the 1% target at 3.8% in June (reported 1 month behind).

RESPONSIVE

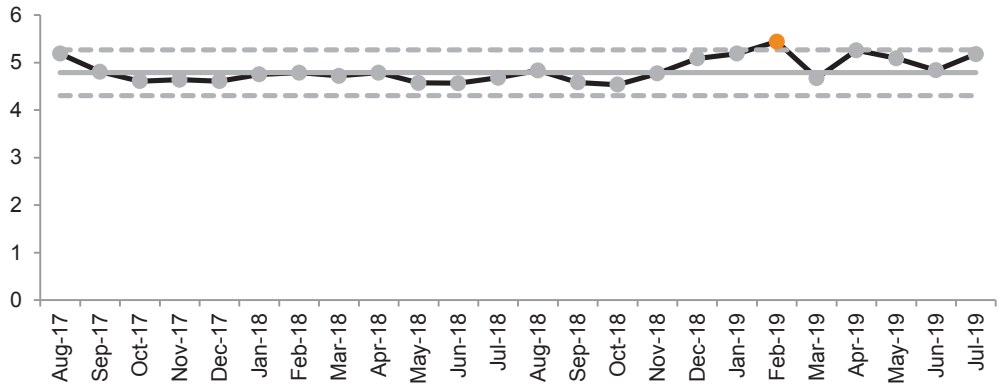
Average length of stay benchmarking

Dr Foster Benchmarking June 18 - May 19

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	62,307	9,385	52,922	3.5	2.7	-0.8
Emergency	59,511	59,511	0	4.5	4.4	-0.1
Maternity/ Birth	13,436	13,436	0	2.1	2.4	0.3
Transfer	199	199	0	11.3	27.1	15.8

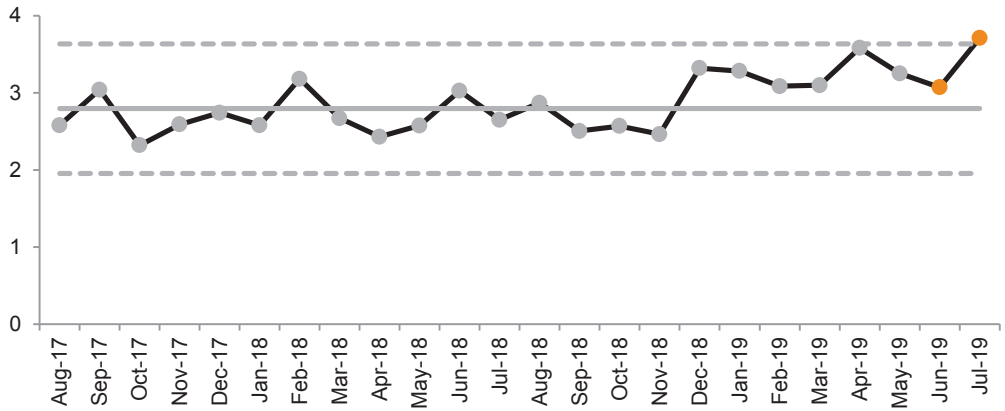
Dr Foster benchmarking shows the Trust length of stay to be below expected for non-elective and elective when compared to national case mix adjusted.

Average length of stay - non elective



The Trust non elective average length of stay is showing no significant change

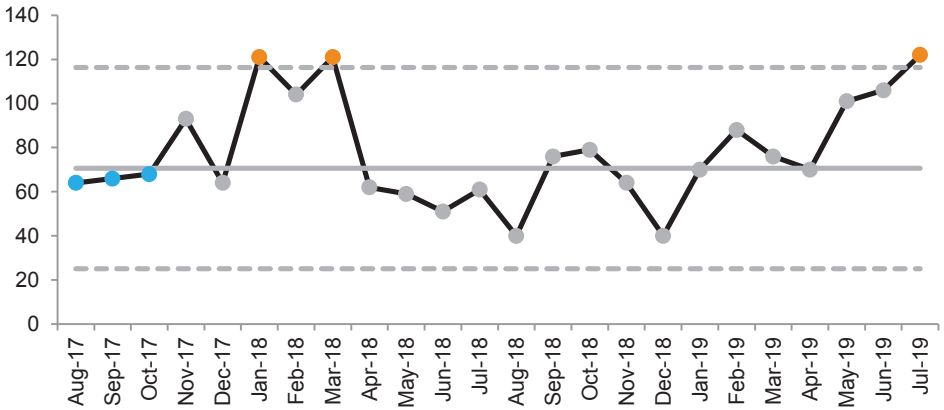
Average length of stay - elective



The Trust elective average length of stay is now showing a significant increase, with the last 8 months above the average of 2.8 days.

RESPONSIVE

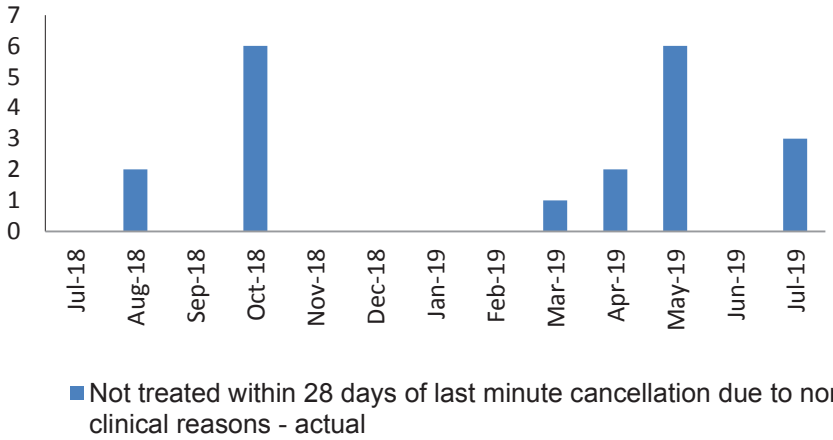
Operations cancelled on day



There were 122 operations cancelled on the day of operation - non clinical reasons, in July.

The trend is now showing significant increase.

Operations cancelled on day - breaches of 28 day standard

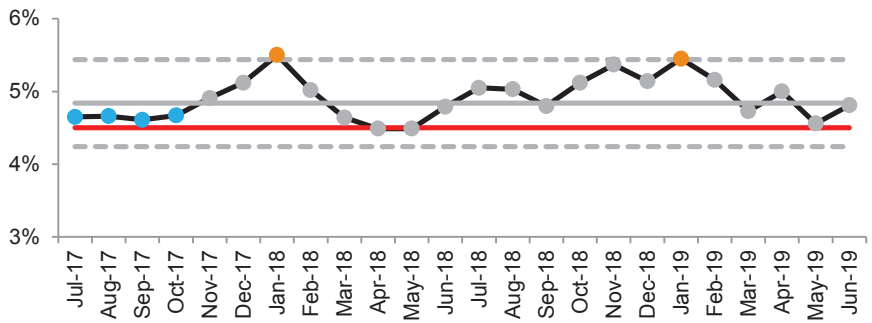


There were 3 'on the day' cancelled operation not rebooked within 28 days in July.

Patients that had procedures cancelled on the day are monitored regularly to ensure dates are offered within the 28 days. Risks are escalated to senior managers and escalated at the weekly operations meeting.

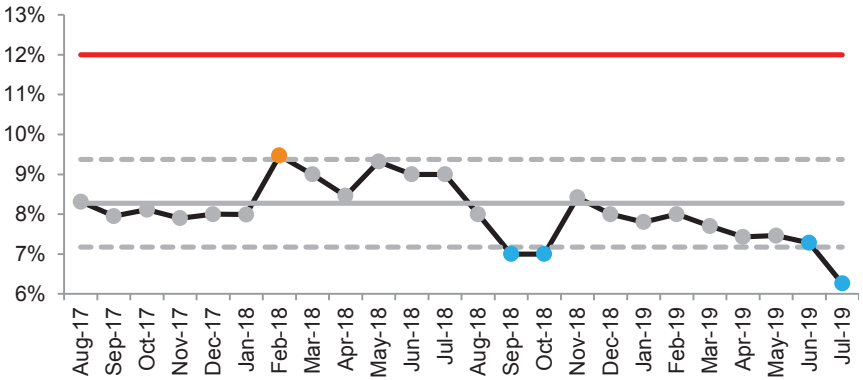
WELL LED

Sickness



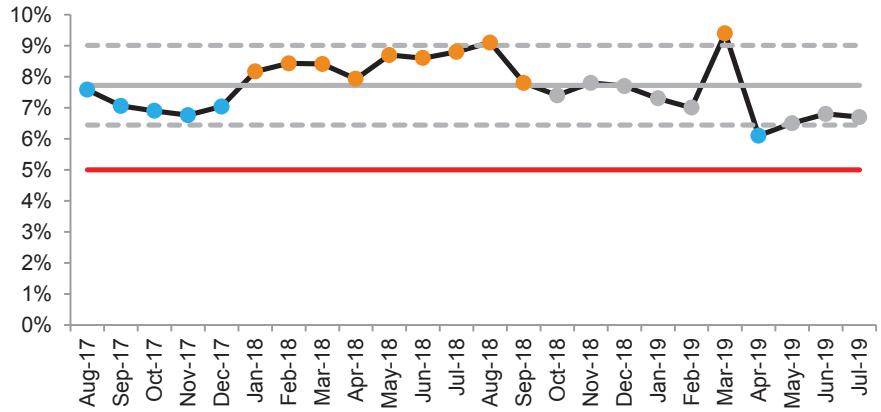
The sickness absence rate is 4.8% for June which is above threshold. The trend is showing normal variation and based on the current level of variaton, may occasionally acheive the target.

Turnover Rate



The trust turnover rate is showing a significant reduction at 6.3% in July which is below threshold. Based on current variation, the indicator will consistently be below the threshold.

Vacancy Rate



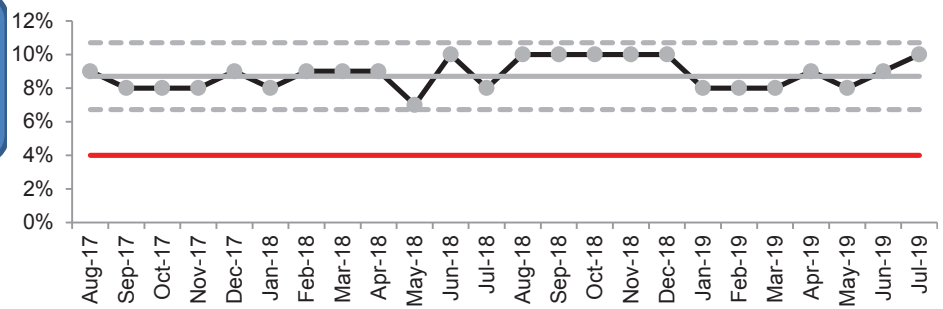
The vacancy rate is 6.7% for July which is above the 5% threshold.

The trend is showing normal variation and based on current variation, will consistently be above threshold.

A detailed action plan has been developed and a quarterly progress update will be provided to the Trust Board.

WELL LED

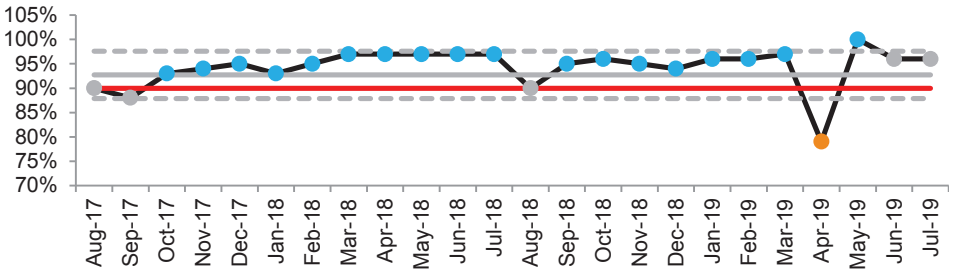
Temporary costs and overtime as % total pay bill



In July 2019 £3.2 million was spent on temporary staff, consisting of £1.3 million on agency staff and £1.9 million on bank staff. Wte staff worked (8,394 wte) was 50 wte more than is funded substantively (8,344 wte). Pay costs are £648K more than budgeted establishment in July.

At the end of July 19 there were 543 vacancies

Appraisals, Consultant

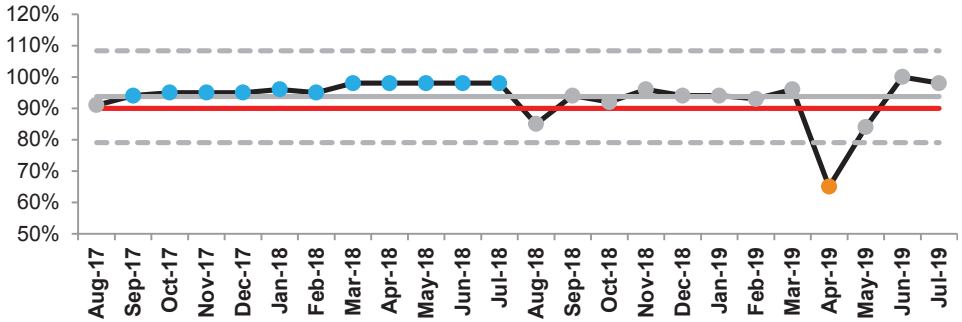


The temporary staffing cost trend shows no significant change and is not capable of hitting the target.

The appraisal rates for consultants and career grade doctors are reported cumulative year to date and reflect the number of reviews completed that were due in this period.

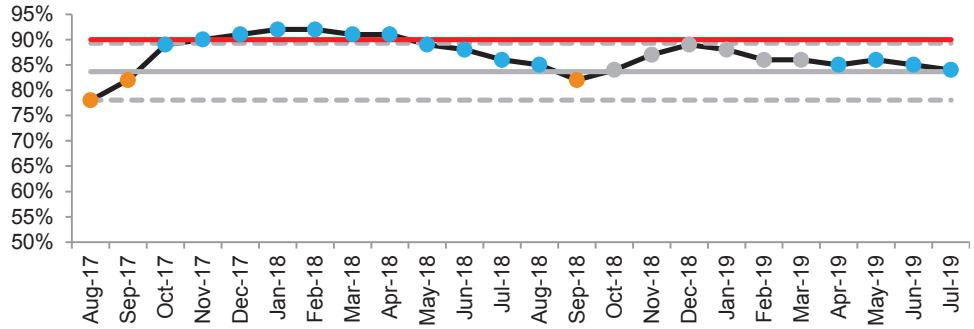
The trend for consultant appraisals is showing normal variation following a drop in April however based on current variation is still at risk of not achieving the target.

Appraisals, Other Medical



The trend for medical staff appraisal rates is showing normal variation, following a drop in April and based on current variation is at risk of non achievement.

Appraisals AFC



The AFC appraisal rate continues to be reported as a rolling 12 month figure and remains below threshold at 84% in July.

The trend is showing improvement, however based on current variation the indicator is not capable of achieving the target

There has been a range of Trust wide actions to support compliance which are on-going. These actions are monitored through the Finance & Performance Committee.

WELL LED

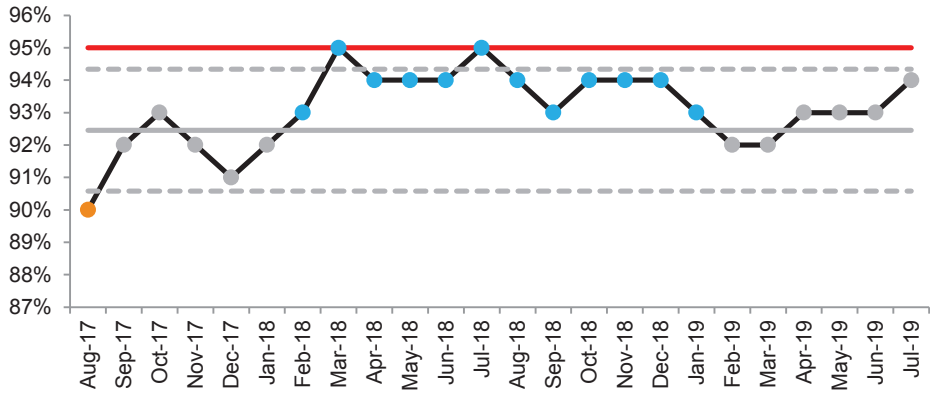
Job Plans

Stage	Consultant	SAS Doctor
Draft	0	
In discussion with 1st stage manager	183	27
1st stage sign off by consultant	24	
1st stage sign off by manager	36	1
2nd stage sign off	41	
Signed Off	20	

There are 304 Consultants and 28 SAS doctors registered with a job plan on Allocate.

The 2019 planning round has been opened since January to be completed by 31 March.

Information Governance Toolkit Compliance



Information governance toolkit compliance is 94% in July below the 95% threshold. The trend is showing normal variation, however based on current variation, the indicator is not capable of achieving the target.

Core Skills Training %

	Target	Compliance at end July
Basic Life Support	90%	93%
Conflict Resolution Training Level 1	90%	98%
Equality, Diversity and Human Rights	90%	97%
Fire Safety	90%	96%
Health, Safety and Welfare Level 1	90%	97%
Infection Prevention	90%	96%
Information Governance	95%	94%
Prevent Healthwrap	90%	96%
Safeguarding Adults	90%	97%
Safeguarding Children	90%	96%
Safer Handling Theory	90%	97%

The core skills framework consists of eleven mandatory training subjects. Training is via a suite of e-learning modules and knowledge assessments on the learning hub (with the option of classroom training available for some subjects). The threshold has been set at 90% for all areas except Information Governance which has a threshold of 95%

Ten of the eleven areas are currently at or above threshold for training compliance rates. Information governance remains below threshold in July.

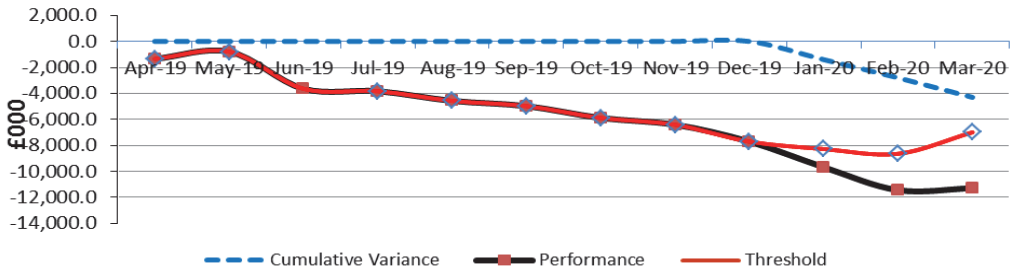
Divisional actions plans to address non-compliance are in place and are being monitored through divisional meetings. Furthermore, a range of Trust-wide measures to support staff to be fully compliant are in place. These include facilitated e-Learning sessions, bespoke training for wards and departments, cascade training and the availability of real-time compliance reporting to assist managers monitor compliance.

WELL LED

Finance & Use of Resource metrics

Area	Metric	Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity	1.5	3	1.3	3
	Liquidity (days)	(5.1)	2	(10.0)	3
Financial efficiency	I&E margin	(0.4%)	3	(0.3%)	3
Financial control	Variance from control total rating	(0.2%)	2	(1.6%)	3
	Agency spend	46.9%	3	35.4%	3
Total			**3**		**3**

Adjusted financial performance (deficit) *



* - excludes PSF allocation

At month 4 the Trust is reporting an underlying £3.8 million deficit in line with the financial plan; and a £0.7 million deficit, after receipt of the 2019-20 non-recurrent Provider Sustainability Funding (PSF) and Marginal Rate Emergency Tariff funding (MRET).

The Trust accepted the 2019-20 Control Total to deliver a £7.0 million underlying deficit giving access to £9.2 million non-recurrent PSF. In addition the Trust is receiving a Marginal Rate Emergency Tariff (MRET) allocation of £4.4 million which is unconditional and will enable the Trust to report a £6.7 million surplus assuming the control total is achieved.

The Safely Releasing Cost Programme (SRCP) is £16.4 million; £2.7 million has been actioned year to date of which £1.5 million (55%) is recurrent. For the full year £6.5 million (40%) has been actioned of which £4.2 million is recurrent. £6.4 million of this is cash releasing.

The Forecast Outturn as at 31st March 2020 is demonstrating a current gap of £4m, assuming the £16.4m SRCP target will be fully achieved on a cash releasing basis.

As a result, the Finance and use of resources (UoR) metrics for year end score has deteriorated to an overall rating of 3 from the planned rating of 2. A reduction in the amount by which agency spend has exceeded the ceiling in month 4 means that 50% limit is no longer in breach, although the overall rating for the financial year to date remains at 3.

The Better Payment Practice Code (BPPC) targets continue to be achieved year to date.

The cash balance at 31st July 2019 of £13.5 million represents an increase of £3.1 million in month.

Efficiency Savings

Division	Green £000s	Amber £000s	Red £000s	Non Rec £000s	Rec £000s	Total £000s	Target £000s	Gap £000s	Green Schemes Annual Non Rec	Green Schemes Annual Rec	Green Schemes Annual Identified
Medicine & Emergency Care	1,179	150	0	0	1,329	**1,329**	2,093	(764)	**0**	**1,179**	1,179
Community & Intermediate Care	0	0	0	0	0	**0**	882	(882)	**0**	**0**	0
SAS	524	226	2,061	359	2,452	**2,811**	4,844	(2,033)	**83**	**441**	524
Family Care	434	538	254	790	437	**1,226**	3,040	(1,814)	**350**	**84**	434
DCS	1,113	0	0	0	1,113	**1,113**	1,113	0	**0**	**1,113**	1,113
Estates & Facilities	470	140	300	259	651	**910**	1,356	(446)	**259**	**211**	470
Corporate Services	250	19	420	0	689	**689**	672	17	**0**	**251**	251
Cross divisional	0	2,612	0	0	2,612	**2,612**	0	2,612	**0**	**0**	0
Targeted Transformation	2,597	0	1,010	2,634	973	**3,607**	2,433	1,174	**1,633**	**963**	2,596
Total	**6,567**	**3,685**	**4,045**	**4,042**	**10,256**	**14,297**	**16,433**	(2,136)	**2,325**	**4,242**	**6,567**

Ward Staff Summary - Jun 2019

Executed on: 03/09/2019 at: 10:15:34 AM

Division: All 3 Available Divisions Selected
Directorate: All 16 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 43 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EC: Surgical & Anaes Services																								
EC02: General Surg Services																								
RBH	5142	Ward C14A	1,260	1,152	91.43%	720	840	116.67%	720	720	100.00%	360	540	150.00%	0	0	0	0	0	0	6.36	26.38%	12.44	2.18%
	5143	Ward C18A	1,302	1,266	97.24%	744	744	100.00%	744	768	103.23%	372	444	119.35%	0	0	0	0	0	0	0.80	3.33%	17.85	2.42%
	5144	Surgical Triage Unit	2,604	2,568	98.62%	1,860	1,776	95.48%	1,488	1,476	99.19%	1,488	1,284	86.29%	0	0	0	0	0	0	-4.41	-15.28%	44.64	4.24%
	5145	Ward C14B	1,260	1,200	95.24%	720	834	115.83%	720	720	100.00%	360	528	146.67%	0	0	0	0	0	0	3.72	15.53%	27.40	4.55%
	5146	Ward C18B	1,260	1,224	97.14%	720	864	120.00%	720	720	100.00%	360	636	176.67%	0	0	0	0	0	0	3.43	14.15%	35.44	5.52%
EC03: Urology																								
RBH	5128	Ward C22	2,160	2,142	99.17%	1,440	1,956	135.83%	1,080	1,416	131.11%	1,440	1,668	115.83%	0	0	0	0	0	0	2.78	9.55%	42.64	5.14%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,254	1,038	82.78%	816	792	97.06%	720	720	100.00%	492	468	95.12%	0	0	0	0	0	0	4.26	13.89%	22.48	2.49%
RBH	5366	Ward B24	1,440	1,254	87.08%	1,080	1,362	126.11%	720	720	100.00%	720	1,152	160.00%	0	0	0	0	0	0	2.75	8.87%	38.96	4.66%
	5367	Ward B22	1,440	1,272	88.33%	2,160	2,040	94.44%	720	720	100.00%	1,800	1,752	97.33%	0	0	0	0	0	0	2.17	4.65%	85.29	6.39%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	6,324	6,258	98.96%	1,152	1,110	96.35%	6,132	6,132	100.00%	420	372	88.57%	0	0	0	0	0	0	19.90	15.81%	171.20	5.44%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,680	3,946	84.32%	1,080	912	84.44%	3,465	3,066	88.48%	315	366	116.19%	0	0	0	0	0	0	7.93	21.27%	44.76	5.08%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,020	1,038	101.76%	534	498	93.26%	760	733	96.45%	315	283.50	90.00%	0	0	0	0	0	0	1.99	7.44%	1.12	0.15%
ED09: Obstetrics																								
BGH	4165	Birth Suite	3,960	3,747.25	94.63%	720	720	100.00%	3,960	3,697	93.36%	720	720	100.00%	0	0	0	0	0	0	-2.61	-3.60%	154.08	6.50%
	4192	Burnley Birth Centre	1,350	1,265.50	93.74%	360	419.50	116.53%	1,080	1,001.50	92.73%	360	325	90.28%	0	0	0	0	0	0	2.70	6.05%	101.60	8.02%
	4200	Antenatal Ward 12	1,840	2,005.50	108.99%	960	842	87.71%	1,080	1,051	97.31%	708	700	98.87%	0	0	0	0	0	0	-1.13	-3.25%	76.72	7.00%
	4203	Postnatal Ward 10	2,328	2,340	100.52%	1,080	1,164	107.78%	2,160	2,196	101.67%	1,440	1,440	100.00%	0	0	0	0	0	0	6.32	10.38%	138.08	8.18%
RBH	5256	Blackburn Birth Centre	900	939.50	104.39%	474	406.25	85.71%	645	645.50	100.08%	322.50	322.50	100.00%	0	0	0	0	0	0	3.94	8.31%	75.68	5.72%
ED11: Neonates																								
RBH	4215	Nicu	4,680	4,494	96.03%	360	192	53.33%	4,320	3,888	90.00%	12	156	1,300.00%	0	0	0	0	0	0	-2.34	-2.93%	84.67	3.36%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,620	1,578	97.41%	1,440	1,620	112.50%	1,080	1,080	100.00%	1,080	1,692	156.67%	0	0	0	0	0	0	19.30	45.20%	9.60	1.37%
EH15: Acute Medicine																								
RBH	5058	AMU A	3,600	3,492	97.00%	2,160	2,508	116.11%	3,240	3,204	98.89%	1,440	1,368	95.00%	0	0	0	0	2	0	10.86	13.04%	53.92	2.33%
	6092	AMU B	3,240	3,108	95.93%	2,160	2,124	98.33%	2,880	2,820	97.92%	1,800	1,800	100.00%	0	0	0	0	1	0	6.89	8.56%	140.84	5.99%

For any queries regarding this report please contact the information department information@elht.nhs.uk
Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

** Vacancies and Sickness metrics include the Staff Groups 'Nursing and Midwifery Registered' & 'Additional Clinical Services' only.*

Ward Staff Summary - Jun 2019

Executed on: 03/09/2019 at: 10:15:34 AM

Division: All 3 Available Divisions Selected
Directorate: All 16 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 43 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EH20: Respiratory																								
RBH	5063	Ward C6	1,440	1,248	86.67%	1,080	1,062	98.33%	1,080	1,116	103.33%	720	696	96.67%	0	0	0	0	0	0	1.70	5.15%	3.41	0.36%
	5064	Ward C8	1,800	1,518	84.33%	1,440	1,404	97.50%	1,080	1,080	100.00%	720	732	101.67%	0	0	0	0	0	0	6.74	17.51%	37.40	3.84%
	6027	Ward C7	1,440	1,218	84.58%	1,080	1,050	97.22%	720	912	126.67%	720	972	135.00%	0	0	0	0	0	0	5.62	18.16%	30.64	3.90%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,440	1,242	86.25%	720	672	93.33%	1,080	1,080	100.00%	0	0	-	0	0	0	0	0	0	2.87	11.70%	4.40	0.63%
	5097	Ward B18	1,740	1,608	92.41%	1,080	1,116	103.33%	1,080	1,068	98.89%	1,080	936	86.67%	0	0	0	0	0	0	-1.36	-4.15%	8.00	0.78%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,440	1,212	84.17%	1,080	1,194	110.56%	1,080	1,080	100.00%	1,080	1,188	110.00%	0	0	0	0	0	0	9.32	26.15%	111.00	14.21%
	5062	Ward C4	1,440	1,194	82.92%	1,080	1,158	107.22%	1,080	1,080	100.00%	1,080	1,116	103.33%	0	0	0	0	0	0	8.27	23.21%	94.64	11.06%
	6103	Ward C11	1,440	1,236	85.83%	1,440	1,488	103.33%	720	720	100.00%	1,080	1,188	110.00%	0	0	0	0	0	0	6.87	19.50%	45.00	5.17%
	6106	C1 (Gastro)	1,800	1,554	86.33%	1,080	1,218	112.78%	720	744	103.33%	360	804	223.33%	0	0	0	0	0	0	8.33	27.53%	31.77	4.78%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,080	792	73.33%	1,800	2,166	120.33%	720	720	100.00%	720	1,404	195.00%	0	0	0	1	0	0	2.34	7.08%	49.76	5.35%
	6094	Ward 16 Sept 13	1,800	1,482	82.33%	1,440	1,830	127.08%	720	720	100.00%	1,440	1,644	114.17%	0	0	0	0	0	0	7.73	18.69%	80.36	7.81%
PCH	4581	Marsden Ward	1,440	1,128	78.33%	1,800	1,716	95.33%	720	720	100.00%	720	1,008	140.00%	0	0	0	0	0	0	4.58	12.11%	32.32	3.19%
	4582	Reedyford Ward	1,440	1,140	79.17%	1,080	1,080	100.00%	720	720	100.00%	720	732	101.67%	0	0	0	0	0	0	2.95	10.11%	92.44	11.45%
	4583	Hartley Ward	1,440	1,116	77.50%	1,080	1,074	99.44%	720	720	100.00%	720	1,044	145.00%	0	0	0	0	0	0	4.22	14.44%	17.62	2.29%
RBH	5023	Ward D1	1,440	1,212	84.17%	1,080	1,044	96.67%	720	720	100.00%	720	876	121.67%	0	0	0	1	0	0	7.56	24.23%	27.96	3.78%
	5036	Acute Stroke Unit (B2)	1,800	1,632	90.67%	1,440	1,410	97.92%	1,080	1,092	101.11%	1,080	1,152	106.67%	0	0	0	0	0	0	5.21	11.16%	110.20	8.75%
	5037	Ward B4	1,440	1,254	87.08%	2,160	2,196	101.67%	720	744	103.33%	1,440	1,452	100.83%	0	0	0	0	0	0	8.50	19.29%	98.32	9.05%
	5048	Ward C10	1,440	1,206	83.75%	1,440	1,434	99.58%	720	744	103.33%	1,080	1,188	110.00%	0	0	0	0	0	0	6.02	16.75%	40.72	4.38%
	6096	Ward C5	1,080	840	77.78%	1,440	1,464	101.67%	720	720	100.00%	1,080	1,464	135.56%	0	0	0	0	0	0	3.33	10.05%	104.73	11.48%
	6105	Ward C9	1,440	1,212	84.17%	1,440	1,446	100.42%	720	756	105.00%	1,080	1,080	100.00%	0	0	0	0	0	0	4.36	12.14%	146.12	14.90%
EH44: Speciality Medicine																								
RBH	5040	Ward D3	1,440	1,248	86.67%	1,080	1,170	108.33%	720	732	101.67%	720	948	131.67%	0	0	0	0	0	0	2.36	8.00%	47.12	5.65%
EH70: Comm In Patient Care																								
CLI	R141	Ribblesdale Ward	1,800	1,566	87.00%	1,440	1,782	123.75%	1,080	1,068	98.89%	1,440	1,788	124.17%	0	0	0	0	0	0	2.38	5.42%	158.44	12.35%
Total for 43 wards shown					**91.04%**			**104.57%**			**98.94%**			**114.68%**	**0**	**0**	**0**	**2**	**3**	**0**	**205.51**	**11.63%**	**2,751.78**	**5.72%**

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Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

** Vacancies and Sickness metrics include the Staff Groups 'Nursing and Midwifery Registered' & 'Additional Clinical Services' only.*

Ward Staff Summary - Jul 2019

Executed on: 03/09/2019 at: 10:18:30 AM

Division: All 3 Available Divisions Selected
Directorate: All 16 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 43 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EC: Surgical & Anaes Services																								
EC02: General Surg Services																								
RBH	5142	Ward C14A	1,302	1,236	94.93%	744	726	97.58%	744	744	100.00%	372	516	138.71%	0	0	0	0	0	0	5.36	22.23%	43.67	7.89%
	5143	Ward C18A	1,302	1,266	97.24%	744	860	115.59%	744	744	100.00%	372	682	183.33%	0	0	0	0	0	0	0.44	1.83%	41.21	5.63%
	5144	Surgical Triage Unit	2,604	2,466	94.70%	1,860	1,842	99.03%	1,488	1,488	100.00%	1,488	1,476	99.19%	0	0	0	0	0	0	-4.05	-14.03%	19.80	2.01%
	5145	Ward C14B	1,302	1,272	97.70%	744	822	110.48%	744	744	100.00%	372	636	170.97%	0	0	0	0	0	0	4.49	18.68%	15.88	2.65%
	5146	Ward C18B	1,302	1,308	100.46%	744	882	118.55%	744	744	100.00%	372	672	180.65%	0	0	0	0	0	0	3.20	13.13%	65.56	9.99%
EC03: Urology																								
RBH	5128	Ward C22	2,232	2,256	101.08%	1,488	1,908	128.23%	1,116	1,416	126.88%	1,488	1,716	115.32%	0	0	0	0	1	0	-4.42	-21.15%	50.00	6.20%
EC04: Orthopaedic Services																								
BGH	4393	Ward 15	1,242	1,050	84.54%	756	744	98.41%	744	744	100.00%	360	360	100.00%	0	0	0	0	0	0	4.25	13.85%	29.68	3.67%
RBH	5366	Ward B24	1,488	1,308	87.90%	1,116	1,356	121.51%	744	744	100.00%	744	1,512	203.23%	0	0	0	1	0	0	2.75	8.87%	47.72	5.50%
	5367	Ward B22	1,488	1,314	88.31%	2,232	2,178	97.58%	744	744	100.00%	1,860	1,860	100.00%	0	0	0	0	0	0	2.17	4.65%	94.73	6.87%
EC09: Anaesth & Critical Care																								
RBH	5362	Elht Critical Care	6,348	6,378	100.47%	1,074	1,020	94.97%	6,150	6,138	99.80%	384	336	87.50%	0	0	0	0	1	0	18.97	15.08%	160.49	4.84%
ED: Family Care																								
ED07: General Paediatrics																								
RBH	5210	Inpatient	4,836	4,164	86.10%	1,116	918	82.26%	3,580.50	3,185.50	88.97%	325.50	388.50	119.35%	0	0	0	0	0	0	-6.48	-21.88%	66.20	6.00%
ED08: Gynae Nursing																								
BGH	4169	Gynae And Breast Care Ward	1,068	1,068	100.00%	558	546	97.85%	800.50	798	99.69%	325.50	304.50	93.55%	0	0	0	0	0	0	2.02	7.37%	9.36	1.20%
ED09: Obstetrics																								
BGH	4165	Birth Suite	4,092	3,701	90.44%	744	750	100.81%	4,092	3,744	91.50%	744	732	98.39%	0	0	0	0	0	0	0.19	0.26%	176.68	7.60%
	4192	Burnley Birth Centre	1,395	1,318.50	94.52%	372	392	105.38%	1,116	1,110	99.46%	372	372	100.00%	0	0	0	0	0	0	3.86	8.65%	25.40	2.00%
	4200	Antenatal Ward 12	1,896	1,922	101.37%	992	992	100.00%	1,116	1,116	100.00%	744	720	96.77%	0	0	0	0	0	0	-1.64	-4.72%	61.12	5.41%
	4203	Postnatal Ward 10	2,376	2,412	101.52%	1,116	1,116	100.00%	2,232	2,064	92.47%	1,488	1,380	92.74%	0	0	0	0	0	0	3.16	5.19%	163.04	9.14%
RBH	5256	Blackburn Birth Centre	930	1,120.25	120.46%	495	450	90.91%	666.50	666.50	100.00%	333.25	333.25	100.00%	0	0	0	0	0	0	4.30	9.07%	17.44	1.30%
ED11: Neonates																								
RBH	4215	Nicu	4,836	4,692	97.02%	372	374	100.54%	4,464	3,948	88.44%	0	156	-	0	0	0	0	0	0	-1.58	-1.98%	69.64	2.74%
EH: Integrated Care Group																								
EH05: Business Support Unit																								
RBH	6078	Ward C3	1,566	1,518	96.93%	1,380	1,416	102.61%	1,008	1,008	100.00%	1,008	1,380	136.90%	0	0	0	0	0	2	17.30	40.52%	15.52	2.11%
EH15: Acute Medicine																								
RBH	5058	AMU A	3,720	3,708	99.68%	2,232	2,508	112.37%	3,348	3,480	103.94%	1,488	1,440	96.77%	0	0	0	0	0	0	11.86	14.24%	59.36	2.68%
	6092	AMU B	3,348	3,222	96.24%	2,232	2,274	101.88%	2,976	2,928	98.39%	1,860	1,776	95.48%	0	0	0	0	0	0	8.25	10.24%	169.00	7.44%

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Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

** Vacancies and Sickness metrics include the Staff Groups 'Nursing and Midwifery Registered' & 'Additional Clinical Services' only.*

Ward Staff Summary - Jul 2019

Executed on: 03/09/2019 at: 10:18:30 AM

Division: All 3 Available Divisions Selected
Directorate: All 16 Available Directorates Selected
Site: All 4 Available Hospital Sites Selected
This report is based on the 43 wards which submitted data for the monthly Safer Staffing return

R: ≥ ±10% | A: ≥ ±5% | G: < ±5% | R: > 0 | G: = 0 | R:≥ 5% | G:< 5% | R:≥ 4.75% | G:< 4.50%

Site	Cost Centre Code	Ward	Day Shift						Night Shift						Pressure Ulcers Acquired			Falls with Harm (Mod & Above)	Infections Acquired		Vacancies WTE (RegN/M + HCA)*		Sickness/Absence RegN/M + HCA)*	
			Registered Nurses / Midwives			Care Staff			Registered Nurses / Midwives			Care Staff												
			Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	Planned Hours	Actual Hours	Average Fill Rate	G2	G3	G4		C Diff	MRSA	WTE Vacant	% Vacant	WTE Days	% Abs Rate
EH20: Respiratory																								
RBH	5063	Ward C6	1,488	1,308	87.90%	1,116	1,110	99.46%	1,116	1,116	100.00%	744	852	114.52%	0	0	0	0	0	0	1.94	5.88%	3.68	0.38%
	5064	Ward C8	1,860	1,602	86.13%	1,488	1,422	95.56%	1,116	1,128	101.08%	744	792	106.45%	0	0	0	0	0	0	6.74	17.51%	53.00	5.40%
	6027	Ward C7	1,488	1,314	88.31%	1,116	1,158	103.76%	744	744	100.00%	744	1,092	146.77%	0	0	0	0	0	0	5.09	16.33%	4.60	0.61%
EH25: Cardiology																								
RBH	5095	Coronary Care	1,488	1,296	87.10%	744	708	95.16%	1,116	1,116	100.00%	0	0	-	0	0	0	0	0	0	0.71	2.90%	23.76	3.35%
	5097	Ward B18	1,812	1,638	90.40%	1,116	1,140	102.15%	1,116	1,104	98.92%	1,116	888	79.57%	0	0	0	0	0	0	-0.36	-1.10%	0.96	0.09%
EH30: Gastroenterlogy																								
RBH	5050	Ward C2	1,488	1,284	86.29%	1,116	1,242	111.29%	1,116	1,104	98.92%	1,116	1,224	109.68%	0	0	0	0	0	0	6.68	19.28%	119.80	14.27%
	5062	Ward C4	1,488	1,290	86.69%	1,116	1,164	104.30%	1,116	1,116	100.00%	1,116	1,116	100.00%	0	0	0	0	0	0	7.27	20.40%	88.72	10.34%
	6103	Ward C11	1,488	1,272	85.48%	1,488	1,416	95.16%	744	744	100.00%	1,116	1,260	112.90%	0	0	0	0	0	0	7.87	22.34%	50.13	5.77%
	6106	C1 (Gastro)	1,860	1,788	96.13%	1,116	1,188	106.45%	744	888	119.35%	372	876	235.48%	0	0	0	0	0	0	9.33	30.83%	3.88	0.60%
EH35: Mfop & Complex Needs																								
BGH	4613	Rakehead Nursing Staff	1,116	840	75.27%	1,860	2,340	125.81%	744	744	100.00%	744	1,344	180.65%	0	0	0	0	1	0	2.38	7.20%	35.88	3.77%
	6094	Ward 16 Sept 13	1,860	1,542	82.90%	1,488	1,848	124.19%	744	744	100.00%	1,488	1,740	116.94%	0	0	0	0	0	0	7.73	18.69%	113.76	10.59%
PCH	4581	Marsden Ward	1,488	1,224	82.26%	1,860	1,812	97.42%	744	744	100.00%	744	1,092	146.77%	0	0	0	0	1	0	4.02	10.63%	41.88	3.99%
	4582	Reedyford Ward	1,488	1,206	81.05%	1,116	1,284	115.05%	744	744	100.00%	744	1,032	138.71%	0	0	0	0	0	0	2.95	10.11%	98.24	12.08%
	4583	Hartley Ward	1,488	1,188	79.84%	1,116	1,152	103.23%	744	744	100.00%	744	1,092	146.77%	0	0	0	0	0	0	4.55	15.58%	15.00	1.93%
RBH	5023	Ward D1	1,488	1,284	86.29%	1,116	1,026	91.94%	744	756	101.61%	744	888	119.35%	0	0	0	0	1	0	9.56	30.64%	36.68	5.32%
	5036	Acute Stroke Unit (B2)	1,860	1,752	94.19%	1,488	1,398	93.95%	1,116	1,116	100.00%	1,116	1,368	122.58%	0	0	0	0	0	0	6.21	13.30%	73.76	5.95%
	5037	Ward B4	1,488	1,278	85.89%	2,232	2,196	98.39%	744	744	100.00%	1,488	1,524	102.42%	0	0	0	1	2	0	6.70	15.21%	98.00	8.70%
	5048	Ward C10	1,488	1,260	84.68%	1,488	1,566	105.24%	744	744	100.00%	1,116	1,260	112.90%	0	0	0	0	0	0	8.66	24.10%	45.80	5.17%
	6096	Ward C5	1,116	930	83.33%	1,488	1,380	92.74%	744	768	103.23%	1,116	1,164	104.30%	0	0	0	0	0	0	3.33	10.05%	123.41	13.35%
	6105	Ward C9	1,488	1,236	83.06%	1,488	1,566	105.24%	744	744	100.00%	1,116	1,404	125.81%	0	0	0	0	0	0	5.36	14.92%	116.48	11.94%
EH44: Speciality Medicine																								
RBH	5040	Ward D3	1,488	1,290	86.69%	1,116	1,242	111.29%	744	756	101.61%	744	936	125.81%	0	0	0	0	0	0	3.32	11.26%	35.04	4.22%
EH70: Comm In Patient Care																								
CLI	R141	Ribblesdale Ward	1,860	1,608	86.45%	1,488	1,782	119.76%	1,116	1,116	100.00%	1,488	1,788	120.16%	0	0	0	0	1	0	2.37	5.40%	148.88	11.56%
Total for 43 wards shown					**92.08%**			**104.43%**			**98.50%**			**117.64%**	**0**	**0**	**0**	**2**	**8**	**2**	**186.81**	**10.67%**	**2,732.84**	**5.64%**

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Report Location: /Operational Reports/Ward Scorecard Monthly Trend/Ward Staff Summary

** Vacancies and Sickness metrics include the Staff Groups 'Nursing and Midwifery Registered' & 'Additional Clinical Services' only.*

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Jun-19

Trust Website where staffing information is available

http://www.elht.nhs.uk/safe-staffing-data.htm

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					midwives/nurses		Care Staff		midwives/nurses		Care Staff									
Site code	Hospital Site name	Ward Name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Nurses & Midwives	Care staff	Overall
RXR60	ACCRINGTON VICTORIA HOSPITAL - RXR60	Ward 2	314 - REHABILITATION		-	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	-			
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		1,800	1,632	1,440	1,410	1,080	1,092	1,080	1,152	90.7%	97.9%	101.1%	106.7%	645	4.22	3.97	8.20
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,740	1,608	1,080	1,116	1,080	1,068	1,080	936	92.4%	103.3%	98.9%	86.7%	745	3.59	2.75	6.35
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		-	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	-			
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,440	1,272	2,160	2,040	720	720	1,800	1,752	88.3%	94.4%	100.0%	97.3%	627	3.18	6.05	9.22
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,440	1,254	1,080	1,362	720	720	720	1,152	87.1%	126.1%	100.0%	160.0%	583	3.39	4.31	7.70
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,440	1,254	2,160	2,196	720	744	1,440	1,452	87.1%	101.7%	103.3%	100.8%	707	2.83	5.16	7.99
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		900	940	474	406	645	646	323	323	104.4%	85.7%	100.1%	100.0%	27	58.70	26.99	85.69
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,800	1,554	1,080	1,218	720	744	360	804	86.3%	112.8%	103.3%	223.3%	353	6.51	5.73	12.24
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,440	1,206	1,440	1,434	720	744	1,080	1,188	83.8%	99.6%	103.3%	110.0%	630	3.10	4.16	7.26
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,440	1,236	1,440	1,488	720	720	1,080	1,188	85.8%	103.3%	100.0%	110.0%	653	3.00	4.10	7.09
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,260	1,152	720	840	720	720	360	540	91.4%	116.7%	100.0%	150.0%	482	3.88	2.86	6.75
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,260	1,200	720	834	720	720	360	528	95.2%	115.8%	100.0%	146.7%	475	4.04	2.87	6.91
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,302	1,266	744	744	744	768	372	444	97.2%	100.0%	103.2%	119.4%	514	3.96	2.31	6.27
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,260	1,224	720	864	720	720	360	636	97.1%	120.0%	100.0%	176.7%	512	3.80	2.93	6.73
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,440	1,212	1,080	1,194	1,080	1,080	1,080	1,188	84.2%	110.6%	100.0%	110.0%	708	3.24	3.36	6.60
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,160	2,142	1,440	1,956	1,080	1,416	1,440	1,668	99.2%	135.8%	131.1%	115.8%	962	3.70	3.77	7.47
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,620	1,578	1,440	1,620	1,080	1,080	1,080	1,692	97.4%	112.5%	100.0%	156.7%	781	3.40	4.24	7.64
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,440	1,194	1,080	1,158	1,080	1,080	1,080	1,116	82.9%	107.2%	100.0%	103.3%	696	3.27	3.27	6.53
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,080	840	1,440	1,464	720	720	1,080	1,464	77.8%	101.7%	100.0%	135.6%	407	3.83	7.19	11.03
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,440	1,248	1,080	1,062	1,080	1,116	720	696	86.7%	98.3%	103.3%	96.7%	719	3.29	2.45	5.73
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,440	1,218	1,080	1,050	720	912	720	972	84.6%	97.2%	126.7%	135.0%	642	3.32	3.15	6.47
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,800	1,518	1,440	1,404	1,080	1,080	720	732	84.3%	97.5%	100.0%	101.7%	531	4.89	4.02	8.92
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,440	1,212	1,440	1,446	720	756	1,080	1,080	84.2%	100.4%	105.0%	100.0%	655	3.00	3.86	6.86
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,680	3,946	1,080	912	3,465	3,066	315	366	84.3%	84.4%	88.5%	116.2%	783	8.96	1.63	10.59
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,440	1,242	720	672	1,080	1,080	-	-	86.3%	93.3%	100.0%	0.0%	248	9.36	2.71	12.07
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6,324	6,258	1,152	1,110	6,132	6,132	420	372	99.0%	96.4%	100.0%	88.6%	564	21.97	2.63	24.60
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,440	1,212	1,080	1,044	720	720	720	876	84.2%	96.7%	100.0%	121.7%	580	3.33	3.31	6.64
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,440	1,248	1,080	1,170	720	732	720	948	86.7%	108.3%	101.7%	131.7%	574	3.45	3.69	7.14
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,600	3,492	2,160	2,508	3,240	3,204	1,440	1,368	97.0%	116.1%	98.9%	95.0%	1129	5.93	3.43	9.36
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,240	3,108	2,160	2,124	2,880	2,820	1,800	1,800	95.9%	98.3%	97.9%	100.0%	1083	5.47	3.62	9.10
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,680	4,494	360	192	4,320	3,888	12	156	96.0%	53.3%	90.0%	1300.0%	829	10.11	0.42	10.53
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		2,604	2,568	1,860	1,776	1,488	1,476	1,488	1,284	98.6%	95.5%	99.2%	86.3%	683	5.92	4.48	10.40
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,840	2,006	960	842	1,080	1,051	708	700	109.0%	87.7%	97.3%	98.9%	161	18.98	9.58	28.56
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,350	1,266	360	420	1,080	1,002	360	325	93.7%	116.5%	92.7%	90.3%	74	30.64	10.06	40.70
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		3,960	3,747	720	720	3,960	3,697	720	720	94.6%	100.0%	93.4%	100.0%	247	30.14	5.83	35.97
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,020	1,038	534	498	760	733	315	284	101.8%	93.3%	96.4%	90.0%	243	7.29	3.22	10.50
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,328	2,340	1,080	1,164	2,160	2,196	1,440	1,440	100.5%	107.8%	101.7%	100.0%	791	5.73	3.29	9.03
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,080	792	1,800	2,166	720	720	720	1,404	73.3%	120.3%	100.0%	195.0%	415	3.64	8.60	12.25
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,254	1,038	816	792	720	720	492	468	82.8%	97.1%	100.0%	95.1%	401	4.38	3.14	7.53
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,800	1,482	1,440	1,830	720	720	1,440	1,644	82.3%	127.1%	100.0%	114.2%	838	2.63	4.15	6.77
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 19	430 - GERIATRIC MEDICINE	MEDICINE	1,440	1,236	1,440	1,596	720	720	720	1,152	85.8%	110.8%	100.0%	160.0%	676	2.89	4.07	6.96
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,800	1,566	1,440	1,782	1,080	1,068	1,440	1,788	87.0%	123.8%	98.9%	124.2%	902	2.92	3.96	6.88
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,440	1,116	1,080	1,074	720	720	720	1,044	77.5%	99.4%	100.0%	145.0%	689	2.66	3.07	5.74
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,440	1,128	1,800	1,716	720	720	720	1,008	78.3%	95.3%	100.0%	140.0%	703	2.63	3.87	6.50
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,440	1,140	1,080	1,080	720	720	720	732	79.2%	100.0%	100.0%	101.7%	656	2.84	2.76	5.60
		Total			84,022	76,422	52,980	55,494	57,874	57,270	36,845	42,581	90.95%	104.74%	98.96%	115.57%	26323	5.08	3.73	8.80

Safe Staffing (Rota Fill Rates and CHPPD) Collection

Organisation : RXR East Lancashire Hospitals Trust
Month : Jul-19

Trust Website where staffing information is available

http://www.elht.nhs.uk/safe-staffing-data.htm

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					midwives/nurses		Care Staff		midwives/nurses		Care Staff									
Site code	Hospital Site name	Ward Name	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Nurses & Midwives	Care staff	Overall
RXR60	ACCRINGTON VICTORIA HOSPITAL - RXR60	Ward 2	314 - REHABILITATION		-	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0	#DIV/0!	#DIV/0!	#DIV/0!
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Acute Stroke Unit (ASU)	300 - GENERAL MEDICINE		1,860	1,752	1,488	1,398	1,116	1,116	1,116	1,368	94.2%	94.0%	100.0%	122.6%	666	4.31	4.15	8.46
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B18	320 - CARDIOLOGY		1,812	1,638	1,116	1,140	1,116	1,104	1,116	888	90.4%	102.2%	98.9%	79.6%	778	3.52	2.61	6.13
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B20	100 - GENERAL SURGERY		-	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0	#DIV/0!	#DIV/0!	#DIV/0!
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B22	110 - TRAUMA & ORTHOPAEDICS		1,488	1,314	2,232	2,178	744	744	1,860	1,860	88.3%	97.6%	100.0%	100.0%	622	3.31	6.49	9.80
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B24	110 - TRAUMA & ORTHOPAEDICS		1,488	1,308	1,116	1,356	744	744	744	1,512	87.9%	121.5%	100.0%	203.2%	613	3.35	4.68	8.03
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	B4	430 - GERIATRIC MEDICINE		1,488	1,278	2,232	2,196	744	744	1,488	1,524	85.9%	98.4%	100.0%	102.4%	721	2.80	5.16	7.96
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Blackburn Birth Centre	501 - OBSTETRICS		930	1,120	495	450	667	667	333	333	120.5%	90.9%	100.0%	100.0%	25	71.47	31.33	102.80
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C1	300 - GENERAL MEDICINE		1,860	1,788	1,116	1,188	744	888	372	876	96.1%	106.5%	119.4%	235.5%	467	5.73	4.42	10.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C10	300 - GENERAL MEDICINE		1,488	1,260	1,488	1,566	744	744	1,116	1,260	84.7%	105.2%	100.0%	112.9%	658	3.05	4.29	7.34
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C11	300 - GENERAL MEDICINE		1,488	1,272	1,488	1,416	744	744	1,116	1,260	85.5%	95.2%	100.0%	112.9%	656	3.07	4.08	7.15
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14A	100 - GENERAL SURGERY		1,302	1,236	744	726	744	744	372	516	94.9%	97.6%	100.0%	138.7%	503	3.94	2.47	6.41
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C14B	100 - GENERAL SURGERY		1,302	1,272	744	822	744	744	372	636	97.7%	110.5%	100.0%	171.0%	500	4.03	2.92	6.95
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18A	100 - GENERAL SURGERY		1,302	1,266	744	860	744	744	372	682	97.2%	115.6%	100.0%	183.3%	531	3.79	2.90	6.69
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C18B	100 - GENERAL SURGERY		1,302	1,308	744	882	744	744	372	672	100.5%	118.5%	100.0%	180.6%	539	3.81	2.88	6.69
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C2	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,284	1,116	1,242	1,116	1,104	1,116	1,224	86.3%	111.3%	98.9%	109.7%	734	3.25	3.36	6.61
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C22	101 - UROLOGY	120 - ENT	2,232	2,256	1,488	1,908	1,116	1,416	1,488	1,716	101.1%	128.2%	126.9%	115.3%	1015	3.62	3.57	7.19
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C3	300 - GENERAL MEDICINE		1,566	1,518	1,380	1,416	1,008	1,008	1,008	1,380	96.9%	102.6%	100.0%	136.9%	585	4.32	4.78	9.10
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C4	301 - GASTROENTEROLOGY	MEDICINE	1,488	1,290	1,116	1,164	1,116	1,116	1,116	1,116	86.7%	104.3%	100.0%	100.0%	727	3.31	3.14	6.45
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C5	430 - GERIATRIC MEDICINE		1,116	930	1,488	1,380	744	768	1,116	1,164	83.3%	92.7%	103.2%	104.3%	421	4.03	6.04	10.08
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C6	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,308	1,116	1,110	1,116	1,116	744	852	87.9%	99.5%	100.0%	114.5%	759	3.19	2.58	5.78
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C7	340 - RESPIRATORY MEDICINE	MEDICINE	1,488	1,314	1,116	1,158	744	744	744	1,092	88.3%	103.8%	100.0%	146.8%	672	3.06	3.35	6.41
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C8	340 - RESPIRATORY MEDICINE	MEDICINE	1,860	1,602	1,488	1,422	1,116	1,128	744	792	86.1%	95.6%	101.1%	106.5%	560	4.88	3.95	8.83
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	C9	300 - GENERAL MEDICINE		1,488	1,236	1,488	1,566	744	744	1,116	1,404	83.1%	105.2%	100.0%	125.8%	696	2.84	4.27	7.11
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Children's Unit	420 - PAEDIATRICS		4,836	4,164	1,116	918	3,581	3,186	326	389	86.1%	82.3%	89.0%	119.4%	742	9.90	1.76	11.67
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Coronary Care Unit (CCU)	320 - CARDIOLOGY		1,488	1,296	744	708	1,116	1,116	-	-	87.1%	95.2%	100.0%	0.0%	248	9.73	2.85	12.58
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Critical Care Unit	192 - CRITICAL CARE MEDICINE		6,348	6,378	1,074	1,020	6,150	6,138	384	336	100.5%	95.0%	99.8%	87.5%	567	22.07	2.39	24.47
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D1	300 - GENERAL MEDICINE		1,488	1,284	1,116	1,026	744	756	744	888	86.3%	91.9%	101.6%	119.4%	609	3.35	3.14	6.49
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	D3	300 - GENERAL MEDICINE		1,488	1,290	1,116	1,242	744	756	744	936	86.7%	111.3%	101.6%	125.8%	606	3.38	3.59	6.97
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUA)	300 - GENERAL MEDICINE		3,720	3,708	2,232	2,508	3,348	3,480	1,488	1,440	99.7%	112.4%	103.9%	96.8%	1232	5.83	3.20	9.04
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Medical Assessment Unit (AMUB)	300 - GENERAL MEDICINE		3,348	3,222	2,232	2,274	2,976	2,928	1,860	1,776	96.2%	101.9%	98.4%	95.5%	1198	5.13	3.38	8.51
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Neonatal Intensive Care Unit	420 - PAEDIATRICS		4,836	4,692	372	374	4,464	3,948	-	156	97.0%	100.5%	88.4%	15600.0%	775	11.15	0.68	11.83
RXR20	ROYAL BLACKBURN HOSPITAL - RXR20	Surgical Triage Unit	100 - GENERAL SURGERY		2,604	2,466	1,860	1,842	1,488	1,488	1,488	1,476	94.7%	99.0%	100.0%	99.2%	661	5.98	5.02	11.00
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Antenatal Ward	501 - OBSTETRICS		1,896	1,922	992	992	1,116	1,116	744	720	101.4%	100.0%	100.0%	96.8%	191	15.91	8.96	24.87
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Burnley Birth Centre	501 - OBSTETRICS		1,395	1,319	372	392	1,116	1,110	372	372	94.5%	105.4%	99.5%	100.0%	60	40.48	12.73	53.21
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Central Birth Suite	501 - OBSTETRICS		4,092	3,701	744	750	4,092	3,744	744	732	90.4%	100.8%	91.5%	98.4%	255	29.20	5.81	35.01
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Gynaecology and Breast Care Ward	502 - GYNAECOLOGY		1,068	1,068	558	546	801	798	326	305	100.0%	97.8%	99.7%	93.5%	271	6.89	3.14	10.02
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Postnatal Ward	501 - OBSTETRICS		2,376	2,412	1,116	1,116	2,232	2,064	1,488	1,380	101.5%	100.0%	92.5%	92.7%	735	6.09	3.40	9.49
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Rakehead	314 - REHABILITATION		1,116	840	1,860	2,340	744	744	744	1,344	75.3%	125.8%	100.0%	180.6%	503	3.15	7.32	10.47
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 15	110 - TRAUMA & ORTHOPAEDICS		1,242	1,050	756	744	744	744	360	360	84.5%	98.4%	100.0%	100.0%	389	4.61	2.84	7.45
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 16	300 - GENERAL MEDICINE		1,860	1,542	1,488	1,848	744	744	1,488	1,740	82.9%	124.2%	100.0%	116.9%	839	2.72	4.28	7.00
RXR10	BURNLEY GENERAL HOSPITAL - RXR10	Ward 19	430 - GERIATRIC MEDICINE	MEDICINE	1,440	1,236	1,440	1,596	720	720	720	1,152	85.8%	110.8%	100.0%	160.0%	699	2.80	3.93	6.73
RXR70	CLITHEROE COMMUNITY HOSPITAL - RXR70	Ribblesdale	314 - REHABILITATION		1,860	1,608	1,488	1,782	1,116	1,116	1,488	1,788	86.5%	119.8%	100.0%	120.2%	915	2.98	3.90	6.88
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Hartley	314 - REHABILITATION		1,488	1,188	1,116	1,152	744	744	744	1,092	79.8%	103.2%	100.0%	146.8%	681	2.84	3.30	6.13
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Marsden	314 - REHABILITATION		1,488	1,224	1,860	1,812	744	744	744	1,092	82.3%	97.4%	100.0%	146.8%	733	2.68	3.96	6.65
RXR50	PENDLE COMMUNITY HOSPITAL - RXR50	Reedyford	314 - REHABILITATION		1,488	1,206	1,116	1,284	744	744	744	1,032	81.0%	115.1%	100.0%	138.7%	663	2.94	3.49	6.43
		Total			86,289	79,366	54,311	56,810	59,426	58,542	37,680	44,632	91.98%	104.60%	98.51%	118.45%	27020	5.10	3.75	8.86

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

11 September 2019

Item 121

Purpose Information
Assurance

Title	Doctors Appraisal and Revalidation Annual Report
Author	Mrs C Schram, Deputy Medical Director
Executive sponsor	Dr D Riley, Responsible Officer, Acting Chief Executive

Summary: This report provides evidence of compliance against GMC and NHS England standards for Medical Appraisal and Revalidation.

Recommendation: The Quality Committee considered the annual report and is recommending to the Board to approve the report and statement for submission to the regulator.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Designated Body Annual Board Report

Introduction

1. This is the ninth annual report on doctors' appraisal to come to the Board, and is the sixth report since the five-yearly cycle of revalidation became mandatory for doctors in 2012. This year, 1st April 2018 to 31st March 2019, was Year 1 of the second 5 year cycle.
2. A Designated Body (DB), is the employing organisation responsible for making a recommendation to the General Medical Council about a doctor's preparedness for revalidation.
3. At the time of writing, there are 497 doctors with a prescribed connection to ELHT as their Designated Body. These are Consultants, SAS doctors and Clinical Fellows. This number changes over the year as doctors start and leave. Doctors in training have a prescribed connection with the Health Education England (North West Deanery) and consequently do not form part of this report.
4. The first national five-year revalidation cycle finished on 31.03.2018. Appraisal and Revalidation is now well embedded at ELHT. This report details the performance and governance in place for medical revalidation and appraisal, using the new report template provided by NHS England. As this is the first year this template has been used, there are no actions from previous years.

Section 1 – General:

The Board of East Lancashire Hospitals NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 20.05.2019 Action from last year: N.A. Comments: AOA was due by 7.06.2019. Action for next year: None

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N.A. Comments: Damian Riley remains the Responsible Officer for ELHT. Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes [delete as applicable] Action from last year: N.A. Comments: The demand on and function of the Appraisal and revalidation Administration team (currently 30 hours at Band 4) has increased over the years, e.g. including the induction of new doctors on appraisal and revalidation, recruitment and development of appraisers, etc. The number of doctors connected to ELHT has risen from 331 in 2013 to 497 in 2019 (a 50% rise). Action for next year: Review the resource for medical appraisal and revalidation administration

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N.A. Comments: There are SOPs in place for ensuring new starters are added to GMC connect, and leavers are removed. These are reviewed regularly. Action for next year: None

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: to review HR 46 **Appraisal Policy for Consultants, Associate Specialists, Specialty Doctors and Non-Deanery Training Grade Doctors.** Comments: HR46 v3.2 was reviewed in June 2018, with a further review date of August 2019 Action for next year: Review HR 46.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: N.A. Comments: Peer review took place in May 2017. A review of the implementation of the recommendations was completed in December 2018. (Appendix 1) Action for next year: Repeat Peer review in 2020

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N.A.

Comments: An induction information bundle for locum doctors has been developed and is provided to all new short term locum doctors. A strengthened process has been put in place to check the identity of locum doctors. Exit report are requested for all locum doctors and provided to the doctor and their agency. Where concerns were raised about a locum doctor, there is direct (deputy) RO to RO information sharing.

Action for next year: Audit processes

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: None

Comments: AOA for 2018-2019 shows that 97% of doctors completed an appraisal (appendix 2). Across England in the same year in the same sector, this was 89%.

Of the 3% who didn't (15), all but 2 had a postponement request approved. Two doctors were the subject of non-engagement letters, and appropriate actions were taken (including informing the GMC). Both have since completed an appraisal (after 31.03.2019). A sample of 20% of all appraisal outputs go through detailed Quality Assurance auditing (QA) using a scored national tool called PROGRESS, while the remaining 80% are subject to a generic QA review without numerical score with structured feedback facilitated to all 100%.

There is a process in place for sharing information about doctors through a standardised template 'letter of good standing' from other places of work to feed into appraisal. This includes information about complaints, significant events, claims and any other concern regarding the doctor signed by the Medical director or delegated deputy from the external organisation.

Within the A&R electronic management system there is a note share system option whereby the (deputy) RO can share information regarding doctors concerns and action plans recommended for appraisal matters with doctor and appraiser in a transparent manner so that this feeds into the appraisal process.

For doctors joining the organisation, and 'MPIT' (Medical Professional Information Transfer) is requested from the RO of the previous organisation. This details whether there were any concerns about the doctor. We provide MPIT to the new organisation of doctors leaving us.

Action for next year: Earlier escalation process for doctors with non-engagement concerns to be incorporated in update of appraisal policy

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Comments: Reasons for delayed (approved and unapproved) appraisals are included in the AOA.

Action for next year: Stream line processes for dealing with late appraisals. Earlier escalation process for doctors with non-engagement concerns to be incorporated in update of appraisal policy

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

Comments: As section 1, question 5.

Action for next year:

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: N.A.

Comments: There are 82 appraisers at ELHT, in line with the recommended 5-10 appraisees per appraiser. 10 new appraisers were trained in February 2019 to ensure succession planning.

Action for next year: Further training planned for November 2019

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and

calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: N.A. Comments: Appraiser network meetings are organised 4 per year. Agendas include updates from national meetings, peer review audits, workshops to develop coaching techniques, External Subject Matter Expert presentations, Health Care leadership model. The network offers a safe forum for appraisers to raise any queries and generate peer discussions. Action for next year: Change in meeting days and times to allow more appraisers to attend. Invite internal subject matter experts, including use of technology. Reinforce and embed health care leadership model within appraisals and include in updated appraisal policy

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: N.A. Comments: See section 1, question 6 Action for next year: QA processes are in place, as is Peer Review, which will repeat in 2020.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Comments: 85 recommendations were made to the GMC, all prior to the revalidation date. (It is possible to make a recommendation when the 'window' opens, 4 months prior to the final date). Of the 85, there were 9 deferrals, all because there was insufficient information to make a recommendation. All recommendations were accepted by the GMC. Action for next year: Continue to improve the number of recommendations made in the early part of the 'window'.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N.A.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: All recommendations are communicated to the doctor. Where a deferral is recommended, an action plan to ensure the new revalidation date is met is agreed with the doctor.

Action for next year: No change.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N.A.

Comments: The GMC's self-assessment tool 'Effective Clinical Governance for the medical profession' was completed and reviewed at the Quality Committee in February 2019 (Appendix 3 and 4)

Action for next year: Implement action plan arising from self-assessment.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N.A.

Comments: Processes for monitoring the conduct and performance of all doctors were included in the GMC self- assessment tool (appendix 4 - Outcome 4 d of the tool)

Action for next year: The self-assessment led to an action to 'Improve accuracy and comprehensiveness of information about incident, claims and complaints provided to individual doctors.'

Resource has since been released from the Medical Director's budget for dedicated time for a Datix administrator to provide relevant information for doctors' appraisal from Datix.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: N.A.

Comments: HR 36v4.1 Responding to concerns about Clinical Performance was ratified by policy council in June 2018, due for review in January 2020. The policy is based on the national guidance 'Maintaining high Professional Standards' and includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action for next year: Review HR36 in by January 2020

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: N.A.

Comments: An audit analysing concerns raised about doctors, including numbers, type and outcome of concerns and protected characteristics is performed annually. Appendix 6 shows the results for 2018.2019, Serious concerns about ELHT Doctors are discussed with PPAS (Practitioner Performance Advice Service) and the GMC ELA (Employment Liaison Advisor).

Action for next year: Continue monitoring.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: N.A.

Comments: Processes for sharing information about doctors were reviewed in the GMC self-assessment (Outcome 4e –'Your organisation's board ensures there are processes are in place to handle and share information relating to clinical governance systems for doctors appropriately.') and found satisfactory.

Action for next year: Audit on information sharing, including MPITs requested for new doctors, exit reports for locums.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: N.A. Comments: Processes to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination were reviewed in the GMC self-assessment tool and found satisfactory. (Outcome 3 A, appendix 4) Action for next year: One action from the self-assessment: To add a section on Equality and Diversity to the Medical appraisal policy.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: N.A. Comments: This was also reviewed as part of the GMC Self-assessment tool (Appendix 4: Outcome 4f: Your organisation's board ensures the necessary checks are in place for doctors before they start work.) All relevant checks are in place Action for next year: No change

Section 6 – Summary of comments, and overall conclusion

Overall conclusion:

The Board is asked to:

1. Receive this annual report and note that it will be shared, along with the annual audit, with the higher level Responsible Officer at NHS England.
2. Approve the 'statement of compliance' section 7, confirming that the organisation, as a designated body, is in compliance with the regulation

Section 7 – Statement of Compliance:

The East Lancashire Hospitals Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: East Lancashire Hospitals NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Appendix 1: Peer Review

Appendix 2: Appraisal Compliance 2018/19

Appendix 3: GMC Self Assessment Tool - Effective Clinical Governance for the medical profession

Appendix 4: GMC Self Assessment Tool -process for monitoring conduct and performance

Appendix 5: Action Plan GMC Governance

Appendix 6: Results of 2018/19 Concerns Raised by Doctors

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 124

11 September 2019

Purpose Information
Assurance

Title	Audit Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/ Assistant Company Secretary
Executive sponsor	Mr R Smyth, Non-Executive Director, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meetings held on 15 July 2019.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No

Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update

At the meeting of the Audit Committee held on 15 July 2019 members considered the following matters:

1. The internal audit reports listed below were presented to the Committee:
   a) Legal Services (Claims) - **Limited Assurance**
   b) Financial Systems – Substantial Assurance
   c) Patient Identification – Substantial Assurance
   d) Completeness of Clinical Records/ Nursing Risk Assessments – Substantial Assurance
   e) Assurance Framework Review – Meets Requirements

   Members noted that the management response to the Legal Services (Claims) report would be presented to the meeting of the Committee that was scheduled for October 2019.
2. The Committee received management responses to the recent Return to Work Processes audit and an update on the progress of the Theatre Stock Management action plan. In relation to the return to work processes response, members noted that the actions being undertaken were due for completion by the end of September 2019, with the exception of those being undertaken to address the recommendation around the need to improve timeliness of sickness absence reporting and maximise the use of PowerBI (the Trust's performance reporting tool) which would be completed by the end of March 2020 as it is dependent upon the completion of the Trust-wide roll out of E-Roster.
3. In relation to the update on Theatre Stock Management, members noted that an electronic theatre inventory system has been purchased and is being implemented with a soft launch being planned for three theatres on the Blackburn site during August 2019. Plans are in place to add one theatre at the Blackburn site per month thereafter with full implementation across both Blackburn and Burnley sites (28 theatres and a procedure room) being planned for January 2021.
4. The Committee members received the progress report from external auditors and noted that the Trust had received a clean opinion on the annual accounts and value for money statement. In addition the Trust had received an unqualified opinion on the Quality Account. The only work remaining on the annual planner related to the annual accounts and report relating to the Trust's Charity, ELHT&Me and would be completed in line with the required timeframes.

5. Members received the Anti-Fraud Service Progress Report and noted the progress being made in relation to referrals and investigations. The Committee members had a discussion about the ongoing false representation case and suggested that the Trust should seek an interview under caution with the individual.
6. The Committee received an update on the Declarations of Interest system. They noted that there was in excess of 1000 decision making staff that were required to make declarations. The total number of declarations received to date was 821, with a further 15 waiting to be escalated or authorised. Of the 821 declarations received, 589 were nil declarations. Members noted that the IT system used to submit declarations would be rebuilt to address some long standing glitches. The initial projected timeline for this work to be completed was noted to be April 2020. Committee members noted the opportunity that this reworking provided to implement some upgrades and revisions to make it easier for staff to submit declarations and to link the system to the appraisal process in an effort to increase compliance.
7. Committee members also received the internal audit follow up report, annual audit letter from the Trust's external auditors, Anti-Fraud annual report 2018/19, minutes from the Trust's Information Governance Steering Group and the results of the committee effectiveness review.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 2 September 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 125

11 September 2019

Purpose Information Assurance

Title	Finance and Performance Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Mr D Wharfe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on 24 June and 29 July 2019.

The Board is asked to note the content of the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Finance and Performance Committee Update Report

At the meeting of the Finance and Performance Committee held on 24 June 2019 members considered the following matters:

1. The Committee received the Integrated Performance Report in its revised format, including an overview of the current financial position to the end of May 2019. The members received an overview of the new style report and the ways in which performance was reported/monitored. Committee members noted that the Trust had received confirmation that Referral to Treatment figures could now include to include the MSK pathways which, once included, had assisted in the slightly improved compliance rate of 90.6%. Members of the Committee also noted that despite efforts to improve further there remained issues in relation to capacity due to pension taxation changes which was having an impact on the willingness of senior clinicians to undertake capacity clinics. The members spent some time discussing this matter and it was noted that an announcement was due from the Government on this matter on or around 28 June 2019, however there remained an underlying issue that there were around 8,000 too few consultants within the NHS. Non-Executive Director members raised concerns that they had previously raised the matter of staffing and recruitment on a number of occasions through various channels and still did not feel assured that the matter would improve, particularly in relation to the medical workforce.
2. The members received the financial performance report for the month of May 2019 and noted that the underlying financial position at the end of May was a deficit of £800,000, which was in line with the financial plan prior to the non-recurrent Provider and Sustainability Funding (PSF) and Marginal Rate Emergency Tariff funding (MRET). The income position at the end of the month was £300,000 below the planned position although it was noted that this is not unusual at this time of the year and would recover in the coming months. Members noted the higher than planned expenditure figures and noted that the majority related to continued use of agency staff.
3. As included in the previous report from the Committee to the Board the Committee were informed that following a review of the Safely Releasing Cost Programme with divisional teams that about £4,000,000 of schemes were now forecast to slip into 2020/21 and that additional schemes would need to be delivered to meet the in-year control total. The Committee discussed this matter at length and raised concerns

about the likelihood of suitable and achievable schemes being identified and actioned in the 2019/20 financial year. The Committee agreed to bring this matter to the Board's attention and will be closely monitoring the delivery of the SRCP schemes.

4. The Committee received the workforce report and Trust's People Strategy was in the process of being developed and would include the work being undertaken locally, regionally and nationally. Members noted that work needed to take place to address the under-reporting of sexual orientation and disability information across the Trust in order that appropriate measures can be put in place to increase the diversity of the workforce and effectively support staff with disabilities. The Committee members noted the revised approach to managing sickness at work and the Trust were exploring the use of electronic return to work interviews. A summary of the work that was being done to improve early access to MSK and mental health services for staff suffering with these issues was also provide to the Committee.
5. Committee members spent some time discussing the Committee specific elements of the Board Assurance Framework (BAF), particularly the proposal to revise the scoring of BAF risk 2 (workforce) from 20 to 25 based on an increase to the likelihood score from 4 to 5. Members discussed the rationale for the request to revise the scoring of BAF risk 2, including the ongoing issues around pension taxation for senior staff and the associated impact on capacity. Members agreed to support the increase to the scoring of BAF risk 2 pending further discussions outside the meeting. The decision was made at the Trust Board meeting in July 2019 not to increase the risk score of BAF risk 2 (workforce) to 25.
6. The Committee also received an update on the vital signs programme, an update on tenders; and the minutes of the Contract and Data Quality meeting for information.

At the meeting of the Finance and Performance Committee held on 29 July 2019 members considered the following matter which is recommended to the Trust Board for consideration:

7. The Committee received the Integrated Performance Report for the month of June and noted that the Trust had met the 62 day cancer treatment standard and the 6 week diagnostic target. Members noted that the RTT performance had deteriorated in the month, with in excess of 3,000 more open pathways than the planned position. The Committee members noted that performance against the four hour emergency department standard for the reporting month was 82.5% which was the below the Trust's improvement trajectory.

8. In addition to the standard report, it was confirmed that the Trust had been selected to take part in the field testing of the new Referral to Treatment (RTT) standards. The Committee received an overview of the new standards that the Trust would need to comply with during the testing and it was confirmed that reporting against the current standards would stop in August and would be replaced by reporting against the new standards. The main change is the move to an average wait time rather than reporting against an 18 week timeframe. Field testing will run until November 2019, followed by a national consultation with a national roll planned from April 2020.

9. The Committee members received the financial performance report for the month of June 2019 and noted that the Trust had reported a £3,600,000 underlying deficit position in line with the financial plan. This figure is prior to the non-recurrent Provider and Sustainability Funding (PSF) and Marginal Rate Emergency Tariff (MRET) funding. After addition of these funds the deficit position was noted to be a £1,100,000 deficit. Members noted that the Trust had received an addition £400,000 in PSF funds following the final consolidation of the NHS provider 2018/19 final accounts. Members spent some time discussing the financial situation at ICP and ICS levels and the potential penalisation of the Trust should the ICS not meet its overall financial control total. Members asked that this matter be escalated to the Trust Board for consideration and potential action. It was agreed that the next report to the Committee in September 2019 would include a clear programme to close the financial gap and meet the required financial control total for the Trust.

10. The Committee also received the tenders report and the minute of the Contract and Data Quality meeting for information.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 2 September 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 126

11 September 2019

Purpose Information

Title	Quality Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Ms N Malik, Committee Chair

Summary: The report sets out the summary of the papers considered and discussions held at its meeting on 26 June 2019.

Recommendation: The Board is asked to note the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation and improvement schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated Care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Quality Committee Update

At the meeting of the Quality Committee held on 26 June 2019 members considered the following matters:

1. The Committee received an update on patient safety matters and noted that there had been one never event reported since the last meeting in May 2019. Executive Director members of the Committee provided an overview of the incident and confirmed that whilst it had been reported and treated as a never event, the incident did not actually constitute a formal never event. However, the Trust was treating it as such to ensure appropriate learning takes place. The incident will be discussed at the Trust's SIRI panel and de-escalated as appropriate following the panel meeting.
2. The Committee received the Maternity Services Floor to Board Report and received an update on progress since the last report to the Committee. The Committee confirmed that they were unable to make decisions in relation to funding or allocation of resources and asked that these matters were addressed with the appropriate colleagues outside the meeting. The Board are asked to note the number of stillbirths in the month of August has reached five.
3. The Committee members received a further update on the Medicines and Healthcare Products Regulatory Agency (MHRA) Action Plan for the Trust's Transfusion Service. Members noted that the target level for traceability is mandated to be 100%. Performance for the Trust, until October 2018, was noted to be 96%. This level has been raised and maintained at 98%, but did not yet meet the 100% compliance requirement, although extra resources and time that the laboratory had been committed. The Committee noted that the Trust was currently working with Iron Mountain to identify any records where tags were missing for the period 2005-2018. It was agreed that traceability of transfusions would be included in the reporting to Divisional Management Boards.
4. The action plan was developed to address a series of recommendations made by the MHRA following audit visits in 2012 and 2018 relating to the need to achieve 100% traceability of infusions. Members noted that the Trust's current traceability compliance was 96% and that an enforcement notice had been issued that could potentially prevent the Trust from performing future procedures if this did not improve. The Committee members noted that among the recommendations made by the MHRA was improved communications between pathology and IT services and changes to the Patient Administration System (PAS) when merging patients.

Committee members acknowledged the urgency of the situation and gave the Committee's support and approval for any further actions needed to achieve compliance by the end of June 2019. It was agreed that IR1 forms would be completed for each case where complete traceability had not been achieved. The Committee requested a further update report from the Transfusion Committee at the next meeting.

5. The Committee received the Serious Investigations Requiring Investigation (SIRI) report and noted the incidents that had been reported through the Strategic Executive Information System (StEIS). Committee members noted that there had been a number of delays in reporting incidents through the StEIS system and the reasons for this related to rapid reviews not being completed in a timely manner or pressure ulcers awaiting verification. Members noted that a deep dive of pressure ulcers had been undertaken, the results of which would be reported to the next available Committee meeting.

6. The Committee received the annual report from the Staff Guardian regarding raising concerns and noted that for the period May 2018 to April 2019, there have been 185 concerns raised which is an increase of 26% from the previous year's figure of 143 and there had been no instances of whistleblowing within the last 12 months. Members noted that a number of emerging themes had been identified and categorised, including concerns relating to potential bullying and harassment from a work colleague (42 cases), patient safety concerns raised (36 cases), with 18 of those raised by staff collectively within an area. The Committee were informed that the area raising the 18 concerns had since been reviewed by the Staff Guardian. A further nine were also collectively raised in relation to staff shortages and 1 to 1 care of patients. Members noted that concerns raised under 'lack of support from managers' covered a range of different issues, including communication between managers and staff teams and lack of compassion from managers. To address these concerns overall, the Trust is in the process of delivering the ELHT Culture and Leadership Programme following completion of the initial discovery phrase. The Trust Board received a summary of this report at its meeting in July 2019.

7. The Committee received the End of Life Care Annual Report and were asked to approve the priorities 2019/20 as outlined in the report. The priorities for 2019/20 were noted to be:

   a) Measure the quality of care delivered to dying patients

b) Improve the quality of care delivered to dying patients
c) Improve the confidence of staff to have difficult conversations
d) increase skills and competence of staff to deliver end of life care
e) Monitor quality of bereavement care delivered
f) Improve the timeliness of procedures after death
g) Establish end of life care education as an essential to role training requirement
h) Collaborate with commissioners to develop seven day working for specialist palliative care services

8. Members noted that whilst ELHT is no longer an outlier for mortality ratio work was continuing to develop the Mortality Reduction Programme. The members noted that, in the future, the number of avoidable deaths and the outcomes of any Learning Disability/Mental Health death investigations will be reported to the Quality Committee. Committee members discussed the rapid discharge procedure that was in place to facilitate the discharge of patients thought to be in the last hours/days of life whose preferred place of death was at home. It was acknowledged that the understanding and usage of the procedure was relatively poor and further information and training was required.

9. The Committee received an update on the Trust's holding lists which is a system used to manage follow up appointments for patients. The members noted that an audit of patients who have been waiting for appointments before January 2019 has taken place and tracking of these patients is being carried out at directorate level. Members noted that an Outpatient Improvement Group has been set up which will drive outpatient transformation with the aim of reducing the demand on follow-up appointments. Members noted that the holding lists position is discussed at Executive level on a weekly basis at the Operational Executive Briefing meetings. In addition the risk has been included on the Corporate Risk Register and noted in the Board Assurance Framework.

10. The Committee received the Committee specific elements of the Board Assurance Framework. The members had a detailed discussion about the proposal to increase the risk score of BAF risk 2 (workforce) to 25 based on an increased likelihood score of 5 (likelihood 5 x consequence 5). The rationale for the increase in scoring was noted to be that the consequences of the risk materialising are being seen to varying degrees across the Trust and the changes to the pension rules and taxation had resulted in a reduction in clinical capacity. Members noted the outcome of the

discussions that had taken place at the Finance and Performance Committee (F&PC) held in June 2019, where the same issue had been raised. The Quality Committee members also noted that the issues relating to Risk 2 may also have an impact on BAF risks 4 (finance) and 5 (performance). Committee members discussed the mitigating factors and felt that the risk did not, at this current stage, require a risk score of 25. It was agreed that the BAF report would be referred back to the Executive Team in order to agree and recommend a final position on the risk score for BAF risk 2. It is worth noting that these discussions took place before the last Trust Board meeting and it was agreed at the July Trust Board not to increase the risk score of BAF risk 2 to 25.

11. The Committee received an update on CQC compliance, Quality Dashboard; an update on the Clostridium Difficile Trajectory, an update on the Trust's Culture and Leadership programme, Corporate Mortality Report; Corporate Risk Register; Draft Quality Account; and Summary Reports from the following Sub-Committee Meetings:

    a) Patient Safety and Risk Assurance Committee (May 2019)
    b) Infection Prevention and Control Committee (April and May 2019)
    c) Health and Safety Committee (May 2019)
    d) Patient Experience Committee (April 2019)
    e) Clinical Effectiveness Committee (April 2019)
    f) Education Directorate Strategic Board (March 2019)

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 29 August 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 127

11 September 2019

Purpose Information Assurance

Title	Trust Charitable Funds Committee Update Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Mr S Barnes, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Trust Charitable Funds Committee meetings held on 13 May and 29 July 2019.

Recommendation: The Board is asked to note the content of the report.

Report linkages

Related strategic aim and corporate objective	NA
Related to key risks identified on assurance framework	NA

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

(127) Trust Charitable Funds Committee Update Report

Trust Charitable Funds Committee Update

At the meeting of the Trust Charitable Funds Committee held on 13 May 2019 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

1. The Committee received the applications to use funds report and noted that there had been one request for funds totalling £20,000 since the last meeting, which was for the purchase of 34 wheelchairs for general use throughout the Trust, which was approved by the Committee. The remainder of the items of expenditure were within the delegated responsibility from the Committee and did not require approval at Committee level.
2. The Committee were updated on the work of the Fundraising Manager, including corporate engagement with a number of local companies and ELHT&Me becoming the charity of choice for the Mayor of Burnley who has pledged to raise £25,000 for the charity. Within the report there was a summary of the various fundraising activities that had taken place, the intention to launch the charity's own lottery via Unity lottery and the launch of a charity mascot 'Elmore'. Members noted that the purpose of the mascot is to have a fun and engaging figure that will become known throughout East Lancashire and can be used at community and hospital events, promotions and for general awareness raising. In addition the Members noted that the charity would be opening an office at the main entrance of the Royal Blackburn Teaching Hospital site in part to raise the profile of the charity but also as a point of donation.
3. The committee received a presentation from the Trust's Surgical and Anaesthetic Services Divisional Management Team regarding the current state of robotic surgery at the Trust and to request additional funding from the Trust's Charity to purchase a second machine for the Burnley site and the replacement of the robot on the Blackburn site. Whilst the Committee members were supportive of improving the robotic services at the Trust, it was agreed that a business case should be developed to support the request including the various forms of possible funding.
4. The Committee noted that the work had commenced to purchase defibrillators and the funds for the purchases were being raised through donation points at EuroGarages facilities.

5. The Committee also received the Investment Performance Report; the Fund Performance and Utilisation Report; minutes of the staff lottery committee; and income and expenditure proposals for 2019/20.

At the meeting of the Trust Charitable Funds Committee held on 29 July 2019 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

6. The Committee received the applications to use funds report and noted that there had been three requests for funds in excess of £20,000. They were noted to be:
   a) £28,829.00 for a scalp cooling system for patients undergoing certain types of chemotherapy
   b) £27,500.00 for an imaging system for Speech & Language Therapy Clinic
   c) £20,200.00 for an endostrobe 4K Workstation

   Members spent some time discussing the correct procedure for applying for and approving requests for funds in excess of £20,000 and noted that the aforementioned purchases had not followed the correct procedure.
7. The Committee were updated on the work of the Fundraising Manager, including the successful bid by ELHT&Me to be the charity of choice for Blackburn Rovers. Within the report there was a summary of the various fundraising activities that had taken place and were planned for the summer months, including a team of runners being entered into the Burnley 10K, a number of participants undertaking the Skipton Tough Mudder and the charity taking part in the Cross Bay Walk in September 2019 to raise funds for ELHT&Me.
8. The Committee also received the Investment Performance Report; the Fund Performance and Utilisation Report; minutes of the staff lottery committee; and income and expenditure proposals for 2019/20.

Kea Ingham, Corporate Governance Manager, 2 September 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 128

11 September 2019

Purpose Information

Title	Remuneration Committee Information Report
Author	Miss K Ingham, Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the Remuneration Committee held on 10 July 2019 are presented for Board members' information.

Recommendation: This paper is brought to the Board for information.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Plan (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Remuneration Committee Information Report

1. At the meeting of the Remuneration Committee held on 10 July 2019 members considered the following matter:
   a) Chief Executive Officer's Annual Appraisal 2018/19 Outcome Letter from NHS Improvement
   b) Pension Update
   c) Director of Communications Remuneration Proposal

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 29 August 2019

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 129

11 September 2019

Purpose Information

Title	Trust Board (Closed Session) Information Report
Author	Miss K Ingham, Corporate Governance Manager/Assistant Company Secretary
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in closed session of the Board meetings held on 10 July 2019.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust's ability to deliver safe personal and effective care. Recruitment and workforce planning fail to deliver the Trust objectives Lack of effective engagement within the partnership organisations of the Integrated care System (ICS) for Lancashire and South Cumbria and the Integrated Care Partnership (ICP) for Pennine Lancashire results in a reduced ability to improve the health and wellbeing of our communities. The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Trust Board Part Two Information Report

1. At the meeting of the Trust Board on 10 July 2019, the following matters were discussed in private:
   a) Round Table Discussion: Pennine Lancashire Integrated Care Partnership (ICP) Strategic Direction and Building a Trusting Partnership
   b) Round Table Discussion: ICS
   c) Finance and Performance Update 2019/20
   d) Tenders Update
   e) Serious Untoward Incident Report
   f) Doctors with Restrictions
2. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Kea Ingham, Corporate Governance Manager/Assistant Company Secretary, 29 August 2019